

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

# Children Looked After and Safeguarding

## The role of health services in Peterborough

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## Contents

<b>Summary of the review</b>	<b>3</b>
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
<b>The child's journey</b>	<b>8</b>
Early help	8
Children in need	15
Child protection	20
Looked after children	27
<b>Management</b>	<b>29</b>
Leadership & management	29
Governance	33
Training and supervision	36
<b>Recommendations</b>	<b>40</b>
<b>Next steps</b>	<b>43</b>

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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 Peterborough. 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 Peterborough, 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 76 children and young people.

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## Context of the review

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*The 2016 Child and Maternal Health Observatory (ChiMat) profile provides a snapshot of child health in Peterborough:*

*Children and young people under the age of 20 years make up 26.8% of the population of Peterborough with 44.8% of school age children being from an ethnic minority group. CHIMAT indicators indicate that the rate of children in care in Peterborough was significantly higher than England rates; however the percentage of these children who were immunised was good. A&E admissions for zero to four years were considerably higher than England averages. Hospital admissions caused by injuries in both children and young people and admissions for asthma and self-harm were also greater than the England average. The teenage conception rate and percentage of teenage mothers in the area has also been found to be higher than England averages.*

*The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months.*

*A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Peterborough. The most recent average SDQ score (2014) shown in the table below was considered to be normal and is below the England average of 13.9. The average score has remained relatively consistent since 2013 which suggests that the emotional health and wellbeing of looked after children in Peterborough is generally stable.*

*Commissioning and planning of most health services for children are carried out by Cambridgeshire and Peterborough Joint Commissioning Unit and Cambridgeshire and Peterborough CCG*

*Acute hospital services are provided by Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). PSHFT provides acute health services to patients in Peterborough, Cambridgeshire, Lincolnshire and Leicestershire, Northamptonshire and Rutland.*

*Community based services are provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). CPFT provide mental health, learning disability, social care, and community services for adults and older people. The trust also provides children's community services in Peterborough.*

*Child and Adolescent Mental Health Services (CAMHS) are Cambridgeshire and Peterborough Foundation Trust (CPFT)*

*Adult mental health services are provided by Cambridgeshire and Peterborough Foundation Trust (CPFT)*

*Cambridgeshire Community Services NHS Trust (CCST) provides community dental, contraception and sexual health and community physiotherapy services to the residents of Peterborough commissioned by Cambridgeshire and Peterborough CCG and Peterborough City Council. The trust also provides a range of community based services across Cambridgeshire, Norfolk, Luton and Suffolk.*

*Lincolnshire Community Health Services run the Peterborough Minor Injury and Illness Unit (MIIU) and Herts Urgent Care who run the GP Out of Hours/111 Service.*

*Young persons and adult substance misuse services are provided by Aspire (Peterborough) Change, Live, Grow.*

*The last safeguarding and looked after children's services (SLAC) inspection took place in March 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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We spoke with people waiting for treatment at Peterborough City Hospital. One parent of a young person they told us:

*"It's been very good. We were asked lots of questions and given a choice of where to wait. So far, so good."*

We spoke with a young person waiting for care and support at the Peterborough minor injuries unit at the City Care Centre. They told us:

*"I don't mind waiting if I need to. Trying to get an appointment at my doctors isn't good so I have had to come here. I know it gets really busy here sometimes but it's worth it. The staff are really nice too."*

The parent of a young person waiting for assessment told us:

*"I suspect he (her child) has only sprained his wrist but best we get it checked out. This service is so convenient for this sort of thing although we have only been here once before. It's all very good."*

In midwifery we spoke with a mother on the postnatal ward. She had used services provided there previously. She told us:

*"They have looked after me very well. Due to previous complications I have had lots of scans to make sure my baby was growing well. The care I have received has been very good throughout although my discharge is taking ages!"*

We met with a young person who had previously used CAMH services. She was accompanied by her mother. They spoke very positively about the service and the support provided to them both:

*“I was quite scared at the start”* the young person told us. *“I was very anxious and needed help there and then. I firstly spoke with my GP and they were very nice and asked me lots of questions. It was a bit embarrassing but I felt better after talking to them. They then made my referral into CAMHS.”*

Mum told us:

*“The doctor asked me to leave during the consultation so they could spend time together. I knew it would be a long and difficult journey but the doctor made me feel better about it. We were seen within seven days of the referral being made they took it that seriously.”*

The young person went on to tell us:

*“The assessment went well and I got on with him (the CAMH practitioner) really well. I was given time to talk and the whole process took over two hours.”*

Mum told us:

*“I stayed for some of the assessment but had to leave part way through which was fine. I understood that and the reason was explained to me. My God I’m glad I met that man. Without him I might not have my daughter here with me today.”*

We continued our discussion and the young person went on to tell us:

*“Every week I met with a psychologist. We discussed coping strategies, breathing techniques and how to talk with my mum and family. We also discussed distraction methods. My mum was involved as little or as much as I liked and I wanted her to be involved. It worked really well. I was placed on special medication which helped and how to reduce them is still discussed regularly. I’m doing well now but it was ‘up and down’ all the time. At one point it was decided I might benefit from seeing a psychiatrist. I had four meetings with them but we just didn’t ‘click’. I talked to my psychologist about this and he suggested another person who I got on really well with. I was always given choices, which was good.”*

They went on to tell us:

*“I’m doing well at school now. I’m completely myself again. I’m more confident and I can face people I wouldn’t have dreamed of doing before. I’ve even been involved in promoting the CAMH service and educating teachers and others about how to recognise mental illness and how best to talk to people in situations like I was in. I’ve even been involved in writing questions for a CAMH user questionnaire. Things are going really well for me now.”*

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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 The dedicated children and young people's waiting area at Peterborough City Hospital (PSHFT) is orientated towards younger children. However, considering the fact that the unit is an adult emergency department with paediatric facilities and further that the physical layout of the building restricts available space, it is considered appropriate to cater specifically to this younger age group. Once children and young people have been booked in at reception they will be triaged by an ED practitioner who has received paediatric foundation training.

1.2 On attending the reception area at PSHFT ED, demographic information is collected and recorded on the causality card. This includes information about ethnicity, religion, GP details and next of kin. However, in cases examined, other important information was not seen to be routinely recorded including documenting the full details of who accompanied children and young people to the department although we did see basic evidence such as 'mother, father, friend'. This is despite the CWILTED paediatric assessment tool (a system which encourages triage nurses to explore more fully the factors leading to the child's attendance to the ED; Condition, Witness, Incident, Location, Time, Escort and Disability) being incorporated into the paediatric admission paperwork. This should prompt ED practitioners to ask leading questions in order to safeguarding children and young people but we saw that if those important questions are being asked, answers are not always being recorded accordingly. This is important as not recording this information has featured in serious case reviews. (**Recommendation 1.1**)

1.3 Children and young people attending PSHFT ED are not always cared for by a registered children's nurse. The ED does not currently have sufficient numbers of registered children's nurses to be able to roster one for each shift. We were informed of challenges and difficulties in recruiting paediatric trained ED nurses and the department recognise the importance of appropriately trained staff being on duty as often as possible and are actively exploring ways to attract nurses to the department. This includes for example, advertising rotational posts within the department. (**Recommendation 1.12**)



1.4 During the booking in stage, all children aged five years and under are routinely checked on the electronic child protection register to identify if they are currently subject to a child protection plan or are looked after. However, this does not currently include children in need cases. Children and young people aged over five years are checked in the same way if there are concerns. We were advised that practitioners are also encouraged to ask whether the family is known to children's social care but we did not see evidence of these questions being asked in records examined. (**Recommendation 1.2**)

1.5 Practitioner oversight of children and young people at PSHFT ED whilst they are waiting for assessment is good. The paediatric and other waiting areas are in full view of the reception area so that interactions between adults and young people can be easily observed. We saw that hospital security staff are also located in the same waiting area providing further opportunities to ensure the safety of vulnerable young people. Practitioners we spoke with are particularly vigilant in recognising the importance of observing relationships between young people and their parents or carers. This includes observation of older young people who might attend with non-family members. Practitioners are well aware of the risk of child sexual exploitation (CSE) and how to recognise such risk.

1.6 All 16-18 year olds are seen and assessed in the adult ED at PSHFT. They are not given a choice of where they would like to be seen for their assessment and any subsequent treatment. Coupled with the absence of dedicated paediatric paperwork, this means that the potential additional vulnerabilities of this age group may be missed. (**Recommendation 1.3**)

1.7 We learned of plans to further develop out-of-hours crisis provision so that specialist CAMHS clinicians would be available until 1am at the PSHFT ED. At the time of our visit this coverage had yet to be implemented although young people admitted to the paediatric ward in mental health distress after 5pm for example, would still see a paediatric doctor who would have access to an on-call consultant psychiatrist. ED practitioners spoke of improved relationships with CAMH which included training for paediatric ward staff in relation to providing care and support to young people located on the ward in mental health distress waiting for an acute bed.

1.8 School nurses are not routinely being notified of ED attendances at PSHFT ED unless the trust safeguarding children's team have been notified of the attendance via a cause for concern form which needs to be completed by the assessing ED practitioner. However, this was discussed with school nurse practitioners during our review and they told us that the method appropriately devolves responsibility for identifying concerns to the practitioner who has contact with the child at the time of presentation for care. This process also allows school nurses to focus their resources and follow up cases of highest need where required. In records examined the cause for concern forms were seen to contain adequate information and information was seen to be shared in a timely and appropriate way.

1.9 School nurses reported that they are not routinely informed if a parent or carer attends PSHFT ED or the City Care Centre Minor Illness and Injuries Unit (MIIU as run by Lincolnshire Community Health Services NHS Trust) with issues that could negatively impact on their parenting capacity or which could place children and young people in a household at increased risk of harm, for example, if a parent presents in a mental health crisis. Reportedly, the same applies to adult services such as alcohol and substance misuse services. This is a missed opportunity for the school nursing team to follow up and engage with children and young people and ensure they are appropriately supported. **(Recommendation 6.1) A letter will also be sent to Public Health informing them of this matter.**

1.10 At the MIIU the SystmOne patient records system does not prompt practitioners to ask important questions about children for whom adults may have responsibility when adults attend after being involved in risk taking behaviours, such as substance or alcohol abuse and are then discharged. Staff are therefore not prompted to ask about the 'hidden child' and record answers given before moving onto the next stage of the assessment process. Likewise, children and young people who attend the unit are recorded as having 'attended with parents' or similar. Sibling details are also not routinely recorded. There is an over reliance on staff professional curiosity to ask and record these important safeguarding questions and a risk that, if they do not do so, children at risk may not be identified. **(Recommendation 7.1)**

1.11 Where possible, children and young people aged 0-19 are prioritised for treatment at the MIIU. Demographic details are recorded at the reception desk and if staff have any concerns a 'pop up' dialogue box appears on all practitioner IT screens when they log onto the SystmOne patient record system. This highlights that a request for an urgent evaluation of whether they are 'safe to wait' has been made. A practitioner will then prioritise assessing the young person to ascertain if it is appropriate for them to wait for care and support in the waiting area or be treated at the earliest opportunity.

1.12 Although there is no dedicated paediatric waiting area at the MIIU we saw that children and young people can be observed by reception staff to note the behaviour of adults attending with them and for any deterioration in the young person's condition.

1.13 There is no available signage in the waiting area at Peterborough MIIU to advise parents and carers that, should practitioners have any concerns in relation to the safeguarding of vulnerable children and young people, that they will routinely share information with children's social care and safeguarding professionals. **(Recommendation 2.1)**

1.14 At PSHFT maternity services, we were informed of good liaison with other health professionals such as; ED practitioners, health visiting, mental health services, substance misuse services and social workers. For example, the 'unborn tracking meeting' is a monthly multi-disciplinary meeting to discuss all unborn cases which are active to children's social care. This meeting enables agencies to share relevant information and have a multi-agency approach to on-going involvement of services. This helps avoid drift, keeps all agencies up to date and enables a degree of professional challenge which is good practice.

1.15 In records seen in midwifery, internal concern forms were used to alert the named midwife for safeguarding children of women's additional needs or vulnerabilities. All forms are reviewed and followed up by the named midwife to ensure appropriate actions are taken and information is placed on patient's records to ensure the identified issues are shared with the wider maternity team. Alerts on the maternity IT systems are used where appropriate to good effect.

1.16 PSHFT has a range of experienced caseload holding advanced midwifery practitioners who provide intensive, individualised antenatal and postnatal care to the most vulnerable cohort of women. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care. The advanced midwifery practitioners are also available to provide advice, education and support to midwifery colleagues with lower level concerns about women in their care. This document gives practitioners good insight into the needs and potential vulnerabilities and can then be further used to better inform the care or recovery planning process.

1.17 The K2 electronic patient records system provides a complete electronic maternity record of a woman's pregnancy and replaces paper and hand-held notes. In using the system midwives are prompted to ask women about domestic abuse at the booking appointment only. The named midwife for safeguarding children is aware that improvement is required to ensure that midwives ask and can demonstrate that routine enquiry is undertaken in each trimester of pregnancy as per trust policy requirements. Following an audit of practice, an action plan has been devised and agreed by both the maternity governance committee and the trust safeguarding committee to monitor improvement.

1.18 Currently, pregnant women in Peterborough are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or other sensitive issues. This could be strengthened by informing women in the antenatal appointment care plan that during at least one visit they will be seen on their own. This will reduce the reliance on professional curiosity in asking an accompanying adult to leave a consultation and therefore the potential for variable practice.

Research widely recognises an increased risk of domestic abuse beginning or escalating during pregnancy and we were reassured that processes are being put in place to support the identification of women who are experiencing domestic abuse and their referral to appropriate support services. (**Recommendation 1.5**)

1.19 We were advised that maternity services routinely receive all domestic abuse risk assessment (DASH) forms completed by the police of domestic incidents where women are reported as being pregnant so that client records can be updated and staff made aware accordingly.

1.20 Pregnant women access maternity services in Peterborough via their GP practice or they can also self-refer into the service. We saw evidence that midwives have a flexible approach to conducting antenatal appointments in a variety of settings including the woman's home address, although most contact is made at midwifery antenatal clinics held within the community.

1.21 In Peterborough, the health visiting team undertake a primary birth visit, a six to eight week check, and one and two and a half year development reviews using the 'ages and stages' questionnaire regarding measurement and child development. Although the two and a half year development reviews are not currently fully integrated, we were informed that in September 2015 a pilot was launched in three localities across Peterborough, working in partnership with the local authority, with a view to roll out the project across the area in due course. It is important that professionals are working together to review development needs of this age group, as it is a key time when specific problems may begin to become problematic. This is a good opportunity to target families that require early help and support.

In addition, three to four month reviews are currently offered to targeted families and through opportunistic contact at clinic visits which may alert the health visitor of additional needs. This is also an important contact as it will enhance early identification of any health needs or support required by the family, which may subsequently impact on long-term health outcomes.

1.22 Health visitor antenatal visits are currently only being offered to those families with known safeguarding concerns and first pregnancies. We were advised that this is due to capacity issues. It is envisaged that once vacancies have been filled all families in Peterborough will be offered antenatal visits, irrespective of identified vulnerabilities. This is an important contact as it can be an opportunity to identify and assess needs, as well as intervene and provide early help to families that require it. However, despite some restrictions, families and children under the age of five in Peterborough benefit from good delivery of the healthy child programme.

1.23 The family nurse partnership (FNP) programme in Peterborough is well established and has been offered to vulnerable families for several years. Providing an FNP service for the most at risk and vulnerable families is important, as it is an evidence-based, preventative service that can reduce inequalities and transform lives of vulnerable young people and their children. The FNP team actively engage with the universal health visiting service when the child reaches the handover age. Joint home visits are offered with the health visiting team to complete the handover and a two year development review is subsequently offered by health visitor team. This helps ensure that families continue to receive support and early help as required.

1.24 Health visitors in Peterborough are supported well by community nursery nurses. This includes completing universal one and two and a half year old development reviews and additional one-to-one work delegated by the health visiting team. Good additional packages of support are currently offered by the nursery nurses, in particular around baby massage, weaning, post-natal groups, behaviour support and including sleep training.

1.25 Young people in secondary schools can access school nursing services via school based drop-in sessions. School nurses aim to offer weekly drop in clinics to all secondary schools where this service is required. This provision extends to weekly health promotion clinics in conjunction with the iCaSH team (Integrated Contraception and Sexual Health), and Young People's Alcohol & Drug Services known as HYPA clinics (Health Young Persons Advisory Clinic). Clinics are offered universally to all secondary schools including Pupil Referral Units. Two secondary schools do not currently have HYPA clinics as they have declined this input repeatedly. The School Nursing Service continues to work with these schools to attempt to gain access for this invaluable service.

The provision of 'in school' clinics help to increase the visibility and accessibility of the school nursing service and allow school nurses the opportunity to identify children and young people who would benefit from early help or signposting to appropriate services.

1.26 In records seen within the school nurse service, the recording of the 'voice of the child' was variable and could be developed further to ensure the views of children and young people are captured and not lost amongst professional opinion. Recording well children and young people's views and concerns demonstrates an inclusive approach to the provision of healthcare services. ***A letter will be sent to Public Health informing them of this matter.***

1.27 The adult mental health team routinely carry out home visits to service users who have children at both the assessment stage and during any re-assessment, such as when a client discloses entering into a new relationship. This is a good opportunity for practitioners to assess the home environment and for any additional risk that might present to children and young people living with adult service users.

1.28 The iCaSH service provides contraception and sexual health services across Peterborough and will give advice and support to young people at locations of their choice. Pro-active guidance, advice and support also plays a large part in the service model with outreach workers having access to nearly all schools in the area as well as attending other areas such as where it is known that public sexual activity takes place with the support of other agencies such as the police.

Comprehensive assessments are undertaken of all young people aged 18 or under. This has resulted in learning from a previous CLAS inspection in Cambridge. This is good practice and the assessment includes discussions regarding the risk of CSE and Female Genital Mutilation (FGM).

1.29 The 'think family' model is well considered in iCaSH services but could be strengthened further with due consideration being given to identifying hidden children of adult service users. There is currently no system to identify and record details of children of adults who have parental or carer responsibilities. We did not examine any records which included such details. ***A letter will be sent to Public Health informing them of this matter.***

1.30 Adult substance misuse (Change Grow Live) practitioners routinely undertake a parenting needs assessment for new clients or when a client's circumstances change, such as when entering into a new relationship. This comprehensive document includes; full children's details, schools and/or nurseries attended, child protection information, social worker name and contact details, identification of need, details of pregnancy and expected birth dates and any impact of the service user's lifestyle choices on parental or childcare responsibility. We examined completed forms and saw that they were appropriately completed.

1.31 In adult substance misuse services the 'think family' approach is well embedded within the service. The consideration given to ensure practitioners identify, record and consider vulnerable children and young people of adult clients is impressive and worthy of recognition. We examined evidence that clearly demonstrated the significant efforts to assess all aspects of the risks and impact placed on the lives of young people by adults who continue to lead often chaotic lifestyles. This includes risk assessments of accommodation and living arrangements where children and young people might be located.

*We examined one record in adult substance misuse services which clearly demonstrated the 'think family' model.*

*An adult client was referred to the service by their GP. At the time of initial assessment questions were asked about their parental responsibilities. When it was disclosed that the new client had children an agreement was made with them to continue the assessment in their own home.*

*We saw that this was undertaken along with a parenting home visit assessment. This clearly documented all persons living at the address, including children and young people. It gave a detailed insight into the appropriateness of the surroundings to adequately safeguard young people along with other assessments of risk that would assist those working with the client to safeguard potentially vulnerable young people.*

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## 2. Children in need

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2.1 All children and young people under the age of 17 attending the ED having undertaken risk taking behaviour or in mental health crisis have their physical health needs assessed and are then transferred to the paediatric ward to await a CAMHS assessment. This takes place either the same day or the following morning. However, children and young people in mental health crisis who are located on the paediatric ward to await a tier four specialist mental health placement are not benefiting from a formal review of the ward environment to assess any risk that they may pose to themselves or others. Risk is assessed in relation to 'risk to self or others'. (**Recommendation 3.1**)

2.2 Young people located on the paediatric ward to await a tier four mental health placement are cared for well. One-to-one mental health care and support is provided and young people are allowed (where practicable and safe) full access to the wards comprehensive facilities, including the use of a safe and secure outside space. This is good practice when caring for this particularly vulnerable cohort of young people.

2.3 We were informed by staff on the paediatric ward that they have good working relationships with the CAMH team. CAMH practitioners and paediatric ward staff meet regularly to discuss how they can improve the experience of CAMH patients located on the ward. This informs practitioners to be more vigilant and alert to possible admissions they may have over the weekend period although discussions do not take place in advance of admissions taking place.

2.4 Practitioners at Peterborough MIIU will provide emergency contraception if requested. Where a young person is aged 16 or under information is routinely shared with iCaSH practitioners to make them aware of the request. Likewise, MIIU practitioners will also signpost young people to the iCaSH service for support and advice when it is considered beyond the remit of MIIU practitioners, such as for sexual health screening. Practitioners at the MIIU report good relationships with iCaSH practitioners.

2.5 All families and children under the age of five years transferred into Peterborough will routinely receive a transfer in visit from a health visitor. The health visiting team will review SystmOne electronic health records and send an appointment letter to the family within 10 working days. This is good practice and an opportunity for early assessment of need and encourages engagement with services.

2.6 If a family transfer's from within the Peterborough area to another part of the city, information regarding local clinics in their new area is sent to the family. However, where there are known safeguarding concerns a more formal handover of care discussion takes place between the health visiting teams to ensure that families continue to receive support in a timely manner.

2.7 A specialist breast feeding health visitor role within Peterborough provides consultation and advice to new mothers. In addition, there are a number of health visitors who have 'specialist interest' in other roles. For example; For example; infant mental health and domestic abuse and maternal mental health and those practitioners also provide support and guidance to the wider health visiting team.

2.8 All GPs in Peterborough have a health visitor attached to their service. Although there is a service level agreement that GPs and health visitors should meet on a monthly basis and not quarterly to discuss vulnerable cases, we were informed that the current arrangements are variable. Therefore, more work needs to be done to ensure that all health visitors have an opportunity to meet with their allocated GP practice to ensure safeguarding cases and families of concern can be discussed.

In cases where health visitors were routinely being invited to attend GP liaison meetings we saw this being clearly documented on SystmOne health records. However, outcomes following discussion were not reflected in the health records so well. **(Recommendation 4.1) A letter will also be sent to Public Health informing them of this matter.**

2.9 In health visiting, we were advised that screening tools are used to assess maternal mood based on NICE guidance questions, as well as including questioning around domestic abuse at each key contact. In most records seen we saw evidence of questions relating to maternal mood and domestic abuse being routinely asked and recorded, and where questions relating to domestic abuse could not be asked this is backed up with clear documentation as to the reason. This helps inform about maternal mental health and the potential impact of domestic abuse upon caring responsibilities as well as identifying support that may be required.

2.10 School nurse services in Peterborough provide school entry screening, height, weight, vision and hearing checks and drop-in sessions to discuss physical and emotional health and other issues that might be troubling young people. However, we were told that there is no capacity for school nurses to undertake proactive health prevention work in schools around topical issues such as FGM although we have since been advised that school nurses undertake small group and individual work with children and young people around topics such as CSE, FGM, healthy relationships, domestic abuse as identified and requested by either school or other agencies. Nursery nurses and health care assistants are currently running pilot 'Clean Gang' health promotion sessions in primary schools addressing issues such as dental hygiene, hand washing etc. **A letter will be sent to Public Health informing them of this matter.**



2.11 Currently there is little capacity for a school nursing team representative to attend GPs vulnerable children/family meetings. GPs and practice managers have been advised that they can contact the school nursing team or allocated school nurse direct to discuss any concerns and there is the expectation that school nurses will contact GPs to share concerns or information as appropriate. The use of a shared IT system is of benefit in this situation as professionals are able to 'task' each other to ensure timely action or notification. However, this is a missed opportunity to develop valuable professional working relationships and to jointly identify and share information around vulnerable children or families. **(Recommendation 4.2) A letter will also be sent to Public Health informing them of this matter.**

2.12 Cambridge and Peterborough Foundation Trust (CPFT) provide co-located community health services for children in Peterborough which includes the looked after health team, the child health team as well as the tier three CAMH service. The CAMH staff we spoke with reported that this arrangement is a strength and allows for the simple and effective exchange of information about children where they cross these services. This is further strengthened by the co-location of all community teams and the CAMH team in one location alongside the trust's safeguarding team, so that discussions about children who are transitioning across services or those who are in need or at risk can take place straightaway and face to face. This enhances the complete and accurate exchange of information, ensuring that key facts are not missed and it also maximises opportunities for children to be signposted onwards or referred to other services.

At the time of our review, however, the looked after children CAMH service is not yet fully developed. Looked after children with neurodevelopmental conditions are seen via the normal pathway by the core CAMH service. We note that the CAMH service have recently prepared a business case to provide a bespoke looked after children CAMH service to work with foster carers on attachment and social and emotional development which will be co-located with the looked after children health team. This post has been recruited to although it will not be implemented until the beginning of October 2016, meaning there remains a service gap in Peterborough until this time. **(Recommendation 5.1)**

2.13 The CAMH service reported that the relationship with the acute hospital was a strength and had fostered a child focussed approach leading to good outcomes for young people who are admitted to the paediatric ward following risk taking behaviours. For example, both the CAMH service and the paediatric ward support mutual staff shadowing opportunities which raises awareness of each other's roles and there are also two paediatric nurses who have a special interest in mental health. This arrangement is further strengthened by other opportunities to enhance the competence of the paediatric ward staff in managing anxieties and escalating behaviour. For example, Paediatric ward staff have developed, in conjunction with CAMH practitioners, 'distraction boxes' onto the ward and CAMHS and the ward staff continue to discuss when to utilise these for individual patients.

Of greater significance is the developing practice of multi-disciplinary discharge planning meetings regarding young people who have been admitted to the paediatric ward for mental health assessment or acute placement. These planning meetings are attended by CAMH clinicians and a number of other professionals who will play a part in supporting a child through a discharge from hospital, and we heard of several examples where these had been effective in ensuring post discharge risks to young people were well managed.

*In one case we were tracking across services a young person had been admitted after harming herself and was thought to be at risk of sexual exploitation due to her behaviour. We noted that a planning meeting had been held involving the CAMHS practitioner, a member of the acute hospital's safeguarding team, the young person's social worker, a representative of the school as well as the young person herself and her parents.*

*The meeting had resulted in a series of action plans tailored to ensure she was properly supported and that action could be taken in the event of any relapse or escalation of the behaviour that had precipitated her initial admission. The action plan was signed as agreed by the child, her family and the professionals present and this had the effect of supported the young person's existing child in need plan. This was a good example of innovative practice that involved the child and her family.*

2.14 The current transitions pathway from CAMHS into the adult mental health service currently starts nine months before the young person's 17th birthday. A three monthly interface meeting is held between CAMHS and adult mental health which is used as an opportunity to identify young people who are likely to transition between services. Each young person is assessed on a case-by-case basis which triggers a professionals meeting and joint working to ensure a smooth transition process. This is important as it can help ensure there is continuity of care for young people, with no delay in them receiving services. However, we were informed that both the CAMHS and adult mental health are actively exploring ways in which to strengthen the transitions pathway, in particular the age at which transition should start. We are aware that a working group is making good progress with this and that contractual arrangements have been agreed to raise the transition age from 17 years to 18 years during 2016.

2.15 Adult mental health practitioners routinely use flags on the RIO electronic patient records system to identify those cases where there are known safeguarding concerns, including those subject to a child protection or child in need plan. This helps to immediately alert practitioners to additional vulnerabilities that need to be considered during assessment or interactions with families. Risk assessment tools are in place and well used on the RIO system, with an additional risk assessment for service users who are caring for children and young people, known as the 'keeping children safe assessment'. In all records seen this assessment was completed by the assessing practitioners and updated as emerging risks became apparent. The full details of children were seen to be recorded in the service user's electronic records and in one particular case examined we saw that the practitioner was proactive in ascertaining the names and dates of birth of all the children in the household from the family GP records, as the client was reluctant to provide this information. This is good practice.

2.16 The adult mental health team offer a limited perinatal mental health service across Peterborough. However, this is currently not commissioned by the CCG. The posts are currently filled by a band seven and a band five practitioner supported by a support worker. We were advised that the current band five practitioner is due to leave the service imminently and that there are currently no plans to re-recruit into the role.

A specialist perinatal mental health service is important for meeting the needs of vulnerable pregnant women and for promoting the emotional and physical wellbeing, and the development of unborn babies. In one case seen, we saw how a perinatal mental health practitioner was able to support a mother to be with severe agoraphobia to access maternity services by initiating joint working. This helped ensure that the unborn baby was safeguarded well and delivered in safe environment. (**Recommendation 5.2**)

2.17 Consideration of young carers was evident in adult mental health assessments reviewed. Where young carers are identified practitioners can refer them to the local young carers group. In one record examined we saw how a practitioner had identified a need for a detailed young carer's assessment and incorporated this information into a report that was produced to inform a review child protection conference meeting.

2.18 Although the efforts put into ensuring the safety of vulnerable young people by adult substance misuse practitioners are recognised and to be applauded, we did find that care or recovery plans for adult clients could be more robust in recording the 'voice of the child' when those assessments are undertaken. In all cases examined, where young people were subject to child protection measures we saw that this was recorded in those care or recovery plans but associated actions were not SMART and did not always articulate clearly what measures should be taken to protect those vulnerable young people over and above measures recommended by the child protection process. **A letter will be forwarded to Public Health informing them of this matter.**

2.19 Among several resources that the CCG have developed for use by GPs is a child in need template form held on the electronic patient database. The purpose of this form is to enable GPs to provide information, in a consistent way across the area, about particular children and their families where a child in need plan is in place. This form has only recently been implemented and so we did not see evidence of its use at this early stage. However, one of the practices we visited told us that their staff were in readiness to use this template and that they expected it to support effective information exchange with children's social care.

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### 3. Child protection

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3.1 ED practitioners are appropriately completing referrals to children's social care when safeguarding concerns have been identified. Initial concerns are reported by telephone which is then followed-up in writing within the recommended timeframe. The referral forms prompt practitioners to provide as much information as possible to better inform the decision making process. However, in cases sampled, completed referrals did not contain an adequate amount of information that would support that decision making process. The referral forms would benefit from more detailed analysis of risk. (**Recommendation 1.4**)

3.2 Play service specialists at PSHFT ED play an important role in identifying child protection and safeguarding concerns amongst children and parents or carers. Practitioners work flexibly across PSHFT including; the out-patient department, the assessment ward, ED and other areas of the hospital where children are located.

3.3 When children and young people are discharged from the Peterborough MIIU the SystmOne record cannot be closed until a chronology of events has been entered onto the patient record. This will then highlight to practitioners at subsequent attendance who they attended the unit with, the reason for their attendance and any safeguarding issues that were addressed or noted. This is good practice.

3.4 Practitioners on the Peterborough MIIU are aware of the areas cultural diversity and how religious and cultural differences can impact on safeguarding practice. For example, when engaging with young people who do not use English as a first language, practitioners are aware of the risk of using family members to translate on their behalf and will use language line even when told it is not necessary.

3.5 At the PSHFT maternity unit, practitioner attendance at pre-birth safeguarding meetings is prioritised and it is expected that a midwife will be present. Attendance is monitored by the named midwife for safeguarding children and included in the safeguarding children dashboard data and safeguarding children quarterly report. The outcomes of safeguarding meetings are placed within women's records to ensure sure the wider team is fully aware of the most up to date information and plan.

3.6 At the PSHFT maternity unit, multi-agency safeguarding referral forms examined were seen to be of variable quality and did not always analyse or articulate risk adequately. Referrals are all copied to the named midwife for safeguarding children and placed in patient's notes. However, there is no formal audit or quality assurance process in place which would help improve the quality of referrals which would increase the likelihood of referrals being accepted and therefore ensure appropriate support is provided to vulnerable women as early as possible. (**Recommendation 1.4 as at 3.1 above**)

3.7 Safeguarding around the time of pre-birth plans, where required, are completed and placed in patient records and shared with the expectant mother (having been developed with them) which is good practice. Mental health care management plans were seen to be particularly robust and include information about early warning signs of deteriorating mental health, current management of care and a plan of care for the early postnatal period.

3.8 The postnatal ward at PSHFT has a swipe card entry system but only a push button release exit. In view of the potential risk of some women absconding with their babies, for example prior to an interim care order court hearing or those in mental health crisis, the hospital may wish to consider changing the ward exit to a more robust system where they can be assured that any risk of absconding with a baby is minimised. Whilst a controlled swipe card exit system cannot necessarily prevent people from leaving a unit, it does give staff the opportunity to try and persuade them to stay. If this is unsuccessful and someone leaves inappropriately, staff will be aware and can act immediately to alert the appropriate authorities to ensure they are kept safe. (**Recommendation 1.6**)

3.9 The midwifery integral risk assessment tool for FGM within the K2 patient electronic records system requires development as this is the prime assessment to determine whether a case should be referred to children's social care. Currently, it does not robustly assess risk sufficiently, particularly around partner and wider family member's views regarding FGM and consequently the risk of FGM to a newborn baby or young child. We were also told that there is no CSE risk assessment tool in use within the maternity department. Although staff have received training on CSE, the lack of a formal risk assessment tool for use where CSE might be suspected means that identifying cases is reliant on individual practitioners recognising potential cases rather than the department having a standardised approach. There is the potential therefore for cases to be missed.

A review of what mandatory information must be input into K2 records should be undertaken as in records examined there were several gaps in information where staff had 'skipped over' sections and not entered required information. This includes; FGM, perinatal mental illness, other mental illness, learning difficulties and information pertaining to new partners. The opportunity to refer women to support services may be missed if vulnerabilities are not identified or recorded. (**Recommendation 1.7**)

3.10 Health visitors in Peterborough offer two appointments before further investigation takes place where families fail to attend pre-arranged appointments. The investigation involves making unannounced visits, discussions with key professionals including GPs, liaison with children's social care teams and discussions with the trust safeguarding team. During the investigation, the SystmOne electronic health record is moved into an 'address unknown caseload' with an additional alert placed onto the record. This is good practice as it demonstrates that the health visitors are proactively working to ensure that children are protected from harm.

3.11 In some records examined, health visitors are recording significant events, for example attendance at strategy meetings, ED attendances, did not attend an appointment etc. in the dedicated safeguarding section on SystmOne. However, we were advised that the effective use of the safeguarding section on SystmOne is down to individual practitioners and is not currently subject to routine oversight but that work is ongoing to amend this gap. It is important that chronologies of significant events are kept up to date as it helps practitioners review the records at a glance saving precious time. This is even more important as health visitors in Peterborough work corporate caseloads, and therefore the same health visitor may not be seeing the family for a universal contact. ***A letter will be sent to Public Health informing them of this matter.***

3.12 Health visitors in Peterborough place alerts for all children receiving targeted health visitor input onto the SystmOne patient record, including those that are on a child protection plan or who are looked after children. However, those children subject to a child in need plan are not currently being 'flagged' onto the system in the same way. The impact of this is that those health visitors who may be new to the case will not be well alerted of all the additional vulnerabilities that they need to consider which is important to help ensure that assessments are robust. Again, this is even more relevant taking into consideration that the health visitors in Peterborough work corporate caseloads. We were informed that a working group, which is supported by the CCG, are looking at how best to utilise the alerts functionality on SystmOne. ***A letter will be sent to Public Health informing them of this matter.***

3.13 Health visitors are notified of, and invited to, attend safeguarding meetings, including child protection conferences, core groups and child in need meetings. We saw evidence of reports being produced for conference which clearly articulated any concerns that the health visitors had, with statutory references to guidance and government legislation to justify and provide evidence underpinning decision-making. This is good practice in informing the decision making process.

3.14 We saw evidence of school nurses making robust child protection referrals to children's social care. The multi-agency referral forms contained an analysis of the identified concerns, articulated risk well and stated the expected outcome of the referral. This is good practice.

3.15 There is a safeguarding agreement with the local authority that if the school nurse service is advised of an initial child protection conference, the school nurse will conduct a health assessment prior to conference (depending on timescales) or within 10 working days post conference. School nurses are supported to prioritise attendance at initial child protection conferences. If no health needs are identified at the health assessment then the school nurse will not be involved in core group meetings thereafter. If the health assessment identifies any on-going health needs then the child or young person may be referred to an appropriate agency or the school nurse may undertake a short period of intensive work with the child/young person (six sessions). If more than six sessions are likely to be required then due to caseload capacity issues, the child or young person will be referred to an alternative agency instead. The school nurse will only continue to be involved safeguarding meetings if actively working with the child or young person. We are assured however, that school nurses will continue to interact with children outside of the safeguarding arena to provide care and support regarding a wide variety of issues. This ensures that those at the periphery of care are supported well.

3.16 The standard of record keeping in the school nursing service was very good. Appropriate use was made of the safeguarding node on the electronic patient record and entries were cross referenced to progress notes and attached files. In each case we could clearly track information about child protection processes and locate source documentation, such as conference minutes, for additional clarity. Diligent record keeping is indicative of thoughtful and safe practice.

3.17 Despite general record keeping within school nurse services being of good quality, in four of the cases we examined we saw that tools used to screen for the risk of CSE were not always used. We saw that risks of CSE were known by the service having been apparent at the point of referral into the team. These risks were alluded to in successive entries and every new risk factor was articulated in the narrative of the progress notes of the electronic patient record; this is expected practice. However, despite a CSE screening tool being available to staff in the trust's safeguarding satchel (a range of resources including policies, guidance and safeguarding forms or templates maintained on each computer desktop), none of the cases examined had benefitted from the use of the tool or of any evolving risk assessment for CSE at each intervention with the young people. This was illustrated in one particular case where the use of an evolving risk assessment or screening tool would have helped the service to assess the impact of some new information in a more effective and timely way. ***A letter will be sent to Public Health informing them of this matter.***

3.18 Child protection plans we saw had key activities tasked to the case holding school nurse; for example, work with one particular child to support her independence with personal hygiene and physical wellbeing. The desired outcomes shown on the plans received from conferences, however, were not time-bound, specific or measurable. It was not clear in the client records whether the school nurse case holder had derived any measurable outcomes from the plans and so there was no means of assessing whether the health actions in the plan were effective. In our discussions with the school nurses we were assured that outcomes from child protection plans were translated into SMART outcomes to direct the work of the nurses. However, the school nurse or health action plans could be strengthened by the inclusion of a set of simple measurable outcomes documented in the child's health record upon receipt of the child protection plan. ***A letter will be sent to Public Health informing them of this matter.***

3.19 Referrals made to children's social care by the CAMH staff use the Peterborough LSCB's multi-agency referral form. We saw that the rationale for each referral was detailed and clearly articulated the risks to the young people concerned. Each form contained sufficient information to provide the receiver with a good insight into the risks and illustrated good competent practice by the CAMH practitioner making the referral.

3.20 CAMH practitioners are fully engaged in child protection processes and prioritise attendance at every initial and review child protection conference to provide information in person. This is always accompanied by a written report for the conference laid out in a structured format and showing protective factors, risks and the voice of the child where the wishes and feelings of the child or young person are clearly stated.

3.21 We saw evidence of adult mental health action plans making reference to children and young people, including some clear actions for practitioners to link with social workers, midwifery teams, health visitors and school nurses with a view to provide updates on the families. This is good, as information sharing can help ensure that vulnerable children and young people are being safeguarded well. However, not all action plans were SMART which is important to help practitioners monitor progress and any drift in a case. ***(Recommendation 5.3)***

3.22 We were informed that if adult mental health practitioners have any safeguarding concerns then they are appropriately completing referrals to children's social care. There is an expectation that all referrals are attached to the service user's health records and forwarded to the trust safeguarding team. However, in two records reviewed referrals made were not attached to the RIO electronic health records, despite the trust safeguarding team database suggesting the referral was initiated by the adult mental health service. Client records were therefore incomplete and do not give a 'full picture' of concerns and actions taken. ***(Recommendation 5.4)***



3.23 In records reviewed, we saw evidence of adult mental health practitioners engaging well with the formal child protection arrangements, including attending child protection, core group and child in needs meetings. Reports for conference are routinely produced, which is important as adult mental health practitioners often have valuable information that can help inform decision making to safeguard children and young people.

3.24 In adult mental health, a daily team meeting is held to discuss all cases where a core assessment has been completed. This meeting is used as an opportunity to identify any safeguarding concerns and offer advice and guidance to the assessing practitioner, for example to make a referral to children's social care or to seek further support from the trust safeguarding team.

3.25 iCaSH outreach workers, along with police partners, monitor sex workers in the area, especially those who are not English nationals. This often transient group receive a good service of care and support regarding their sexual health needs but the process also means that outreach workers can assess risk to younger people, especially those who might be subject to sexual exploitation. This is but one initiative undertaken by the team to identify vulnerable people in Peterborough and is to be applauded.

3.26 eCAF is an electronic version of the common assessment framework (CAF) whereby practitioners who are working with children, young people and families as part of the CAF process can share information in a secure, efficient and appropriate way. In adult substance misuse, cases are not closed while social care are still involved with the clients children. Processes are in place to routinely check the eCAF system to identify other agencies involvement and therefore assist joint working to protect vulnerable young people. This ensures vulnerable children and young people remain at the fore of practitioner interactions with adult clients who have parental or carer responsibility.

3.27 Across health we saw variability in the way that practitioners are invited to attend child protection meetings and also what information is then shared following meetings taking place. For example, we saw in iCaSH an incidence where the outreach worker had been invited to attend an initial case conference. The practitioner not only attended the meeting but also provided a comprehensive report and was further tasked to provide care and support to the subject of the meeting following the meeting. However, despite their involvement in the case they were not invited to attend a subsequent review meeting and so could not appropriately inform the decision making process. ***A letter will be sent to Public Health informing them of this matter.***

3.28 Referrals made to children's social care via the MASH are generally of good quality, with only some exceptions, and articulate well risk to vulnerable children and young people. However, we saw that referrals made by GPs in Peterborough are not of equivalent quality. Examples seen did not always articulate risk and any suggested outcomes that might be beneficial following further action.

A recent audit of GP safeguarding practices carried out under section 11 of the Children Act 2004 showed that report writing for child protection conferences was recognised as generally not being of a good standard. In order to address report templates have been developed. Their purpose is to support GPs to share information with child protection conferences consistently and presented in a way that examines risk, protective factors and the wishes of the child. We acknowledge that this form had only recently been implemented at the time of our visit and was embedded into the procedures for only one of the three practices we visited.

***(Recommendation 4.3)***

3.29 It was disappointing to note that in two of the cases reviewed in GP surgeries they had not been notified of the outcome of the referrals and there was no formal mechanism that prompted the practices to chase up such information. Therefore, it was not clear if these referrals had subsequently been subject of child protection enquiries. This information is important to enable GPs to manage subsequent consultations with vulnerable children and young people in their care.

***(Recommendation 4.4) A letter will also be sent to Public Health informing them of this matter.***

3.30 In two GP practices visited, we saw that child protection conferences are not routinely attended by GPs. We noted that late notification of conferences was usually cited as the reason for not being able to schedule time to attend, and in cases sampled we saw that this was also often due to no invitation being sent to the GP in the first place. However, in every case where GPs are made aware of child protection conferences in a timely manner, we saw that a report is sent in lieu of their attendance. The standard of the content of these reports is however, variable; in two of the practices visited we saw that a letter is sent that outlines the most recent clinical presentations whilst in a third practice the report sometimes consisted of little more than a printed summary of the child's last attendance and a record of their medications. This is not effective practice as it does not help conference to interpret risks to the child's health. ***(Recommendation 4.5)***

*As noted above, It is generally the case in the practices we visited that GPs are not able to attend child protection conferences due to their workload and commitments to patients in their care. However, we examined one complex case in one of the practices visited where there were concerns about an illness in a primary school aged child that was suspected of being factitious. We noted extraordinary participation by the GP, not only in the child protection review conferences but also in the regular child protection core groups and this demonstrates good practice.*

*It is unusual to see GPs involved in core groups to this extent and we mention it here because it shows good support in ensuring clinical information was clearly understood by the multi-agency participants, often an area of difficulty in such cases. It also shows commitment to achieving good outcomes for children in their care as well as strong safeguarding leadership in what is considered to be a difficult area of practice.*

*At the most recent review conference, we saw that the risks had been managed effectively and so the child was stepped down from a child protection plan to a child in need plan.*

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## 4. Looked after children

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4.1 All looked after children, and those on a child protection plan who attend the ED, routinely have their attendance shared with children's social care to share information regarding the reason for attendance and any concerns identified during the assessment. This means that children's social care have access to all important information relating to looked after children health needs. Attendances are also notified to the looked after children health team. The looked after children team are proactive in reviewing and following up any concerns with the young person or carers as necessary. This means that any existing or emerging health needs are quickly identified or followed-up.

4.2 Initial health assessments are carried out by a paediatrician and this is in line with statutory guidance. Initial health assessments seen were appropriate, identifying the health needs of children coming into the care system with some evidence of consideration being paid to parental health histories and the likely impact on the health of the child, particularly in relation to foetal alcohol syndrome. Efforts were made to engage young people in their health reviews even when they were difficult to engage. For example, in one case seen this involved the named nurse speaking to professionals, working to support the young person to create a health care plan which will be shared with the young person on completion.

4.3 Health plans arising from initial health assessments and review health assessments are not always SMART and outcome focused. Plans examined contained activities rather than having a clearly defined outcome. For example, 'encourage healthy eating' rather than 'reducing weight' with clear actions on how to do so. This means it is difficult to demonstrate a positive impact on the health of the child.

Quality assurance of initial health assessment and review health assessments is currently underdeveloped. There is no formal routine quality assurance or audit programme to measure and improve the quality of initial and review health assessment. There is however, peer review between professionals across the service. The designated nurse is introducing a formal quality assurance programme, which is due to commence in June 2016. This is important for informing service development and the health of LAC in Peterborough. (**Recommendation 5.5**)

4.4 Children and young people in Peterborough are benefiting for timely review health assessments carried out by specialist looked after children health nurses, who also demonstrate a commitment to reflecting the voice of the child in assessments seen. For the older children and young people there was evidence that consent and confidentiality had been discussed. However, we were not assured that looked after young people are appropriately being targeted, particularly relating to review of risk assessments around vulnerability and CSE. The policy is for age appropriate young people to have a risk assessment and where necessary a screening for CSE assessment, however, in some cases seen this has not taken place. (**Recommendation 5.6**)

4.5 In all cases seen, growth measurements were being observed and charted against centiles. However, in one case seen there was a significant variation in the centiles over a six month period but this was not explored in any depth. This could present a missed opportunity to identify and intervene in an emerging health need. (**Recommendation 5.7**)

4.6 In preparation for initial and review health assessments taking place, the looked after children's health team collate and collect information from a range of health professionals including health visitors, school nurses and primary care. However, in records reviewed there is an overreliance on SystmOne and combined with practitioners not documenting the sources and associated research activity, we could not be assured that all reviews and assessments were being informed by health information held outside of SystmOne records. This is a missed opportunity to gather important information as part of children and young people's care pathway. (**Recommendation 5.8**)

4.7 Children and young people are now benefiting from the use of strength and difficulties questionnaires (SDQs). These are routinely sent out by the looked after children's health team prior to the health review, which are subsequently scored on their return and so go on to inform the review. The health review form has been amended to incorporate a review of the score in order to better inform the care planning process.

4.8 Children and young people placed out for the local area do not always benefit from a robust review of their health needs. This is recognised by the partnership, and arrangements are being strengthened to ensure that these vulnerable children receive a comprehensive assessment, through the use of clear service specifications and payments by results.

4.9 Children and young people who have additional emotional health and well-being needs do not benefit from timely specialist CAMHS input. Although there is a local authority looked after children psychology service, children who require specialist tier three care and support are not prioritised within the CAMH service. The looked after children health team are unable to identify those children who had been referred into CAMHS and how long they had been waiting for assessment. This is not acceptable. (**Recommendation 5.1 as at 2.12 above**)

**N.B.** We have since been advised that children in care are currently prioritised for assessment although there is no clear standard operating procedure regarding this.

4.10 Care leavers are not currently benefiting from health passports. This means that young people are not currently benefiting from important health information in a timely way. This is recognised as an area for development. We were informed that consultation is progressing with young people on this matter to develop a new health passport. Young people often tell us how important it is for them to have as ‘full a picture as possible’ of their health history on leaving care. (**Recommendation 5.9**)

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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 Midwives in Peterborough do not conduct regular meetings with GPs but community midwives can access SystemOne to view patient records when working at GP surgeries. We were advised that GPs are routinely informed when a woman books for maternity care via a ‘notification of pregnancy’ standard letter. GPs hold essential information about patient’s current and historical health and social issues which may impact on parenting capacity. The ‘notification’ letter could be strengthened by specifically requesting that GPs share relevant information to aid an overall risk assessment of potential harm to unborn children. (**Recommendation 1.8**)

5.1.2 The K2 electronic patient record system is relatively new to the maternity department at PSHFT and there are sections within the system which it is acknowledged require improvement. Once the paperless package is fully functioning it will ensure that maternity notes are a comprehensive and up to date single record of care which will ensure essential information is available to all staff caring for pregnant women. Women can also view their maternity notes through a secure web-based portal on electronic devices that are connected to the internet, such as laptops, tablets and android phones.

5.1.3 The named midwife has systems and processes in place to ensure she has a good oversight of safeguarding cases within the maternity department at PSHFT. There is a clear governance structure and regular meetings ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board.

The safeguarding children dashboard captures a wide range of data and activity including the number of concerns raised, the number of referrals made to children's social care and the number of cases where the escalation policy has been used.

5.1.4 Health visitors in Peterborough attend a monthly professional's programme which is available to all staff, including the FNP team and nursery nurses. The meeting provides senior managers with an opportunity to provide service updates and also when relevant to invite other professionals, including paediatricians, speech and language therapist, dieticians, substance misuse services etc. This assists practitioners to keep up to date with emerging local and national trends and needs.

5.1.5 The health visitor-midwifery liaison meeting in Peterborough is reported to be variable in the way that it takes place. However, there is a clear antenatal pathway in place which has helped strengthen information sharing between the services. Health visitors informed us that once they are notified of a new pregnancy via a SystemOne task, the records are reviewed prior to offering an antenatal contact to ensure the pregnancy is still viable.

5.1.6 We were informed of a monthly 'unborn baby panel' meeting which is attended by the health visiting lead, midwifery service and children's social care to discuss families that are already known to social services. This is good practice as it enables health visitors to have the most up-to-date information prior to scheduling antenatal contact.

5.1.7 School nurses in Peterborough spoke of good inter-agency and multi-agency communication with other professionals including health visitors, CAMHS, iCaSH and social services. This was also evidenced in many of the files we examined. This is important to ensure children and young people are well supported and their care is co-ordinated across multi-agency partners.

5.1.8 The SystmOne electronic patient record used by school nursing is also used by all GPs within Peterborough and also the health visiting service. The common use of SystmOne by these services helps to ensure that a young person's health record is comprehensive and able to be shared (with appropriate permission) between health practitioners. This is particularly valuable to ensure relevant health practitioners have a good overview of cases where vulnerabilities or complexities have been identified or are emerging.

5.1.9 CPFT are commissioned to provide school nursing services to a school population of approximately 45,000 from age five to 19. Approximately half of this population are secondary school pupils. School nursing is a universal, prevention and early intervention service open to all children and young people in mainstream and special schools and pupil referral units who are registered with a GP in Peterborough and/or attend schools within Peterborough City Council local education authority.

However, the school nursing service is not currently commissioned to provide care and support in independent schools, further education colleges or for children educated at home.

We were not supplied with specific caseload sizes but it was agreed that they exceeded the guidance from the Community and Public Health Visitor Association (CPHVA) of not exceeding 1200 children. ***A letter will be sent to Public Health informing them of these matters.***

5.1.10 The school nursing team is very focused on the level of service they are able to offer to children and young people and have worked on managing other professional's expectations of what the school nursing provision is in Peterborough. This means that there is a better multi-disciplinary understanding of school nursing roles and responsibilities.

5.1.11 CAMH waiting lists for ADHD and ASD were re-introduced in December 2015 following suspension, and waiting times for core CAMH services have now been significantly reduced due, in large part, to the trust's response to an action plan agreed with the CCG and the joint commissioners. The effect of recruiting additional staff to meet increased demand has resulted in all young people requiring assessment for core CAMH pathways and for ADHD being seen within 18 weeks. The projection for ASD is to achieve the same reduction by the end of the first quarter of this financial year. This is a significant improvement although the trust acknowledges that there is still work to do to ensure the impetus leading to the improvements in capacity is maintained.

5.1.12 In one of the cases we were tracking across services and in another case we sampled, we saw evidence of robust escalation of issues to resolve areas of professional discord between the CAMH staff and the local authority. The rationale for escalating these cases was supported by good record keeping and a clear articulation of the risks that applied to each of the young people. These cases highlighted a strong safeguarding culture within the CPFT.

5.1.13 We saw that the Peterborough CAMH service had hosted a conference regarding deliberate self-harm aimed at staff from local schools including teachers, SENCOs and staff in the pupil referral unit. The purpose of this conference was to heighten awareness among education staff of the effects on the young person of differential responses to self-harm. This demonstrated a clear intent by the trust to enable other agencies to recognise the impact of such behaviours and to take early opportunities to support or signpost young people to relevant services.

Moreover, the content of the conference had been informed by survey responses of young people and other professionals and had been developed with the help of a young person and her parents who had provided valuable insight into the effects of such behaviour on families. The involvement of the young person added to the experience of the conference delegates and aided their understanding of this behaviour as evidenced by the positive evaluations of the group. We met with the young person concerned and heard about the positive impact the CAMH service has had in her and her family's life and further how on-going involvement in service training and development continues to aid her own self esteem.

5.1.14 The adult mental health service is represented at the Multi-Agency Risk Assessment Conference (MARAC) meetings where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. All relevant information is then shared back with individual practitioners and team managers via email, which is then entered onto the RIO electronic client health record. This ensures that the most relevant up to date information is available to all practitioners working with service users. In addition, it alerts practitioners to consider additional vulnerabilities, which also helps to inform decision-making during assessment of need.

5.1.15 In almost every case we sampled in the GP practices, we found evidence of limited or variable engagement with them by children's social care. This ranged from the absence of conference invitations or minutes to limited contact regarding referrals made by GPs. Conversely, we saw from the records of the cases that health visitors and school nurses were generally well engaged by children's social care; the effect of this is to create a reliance on the child health teams to manage the information streams and to leave the GPs as seemingly secondary to the process. This is not best practice as it means some information may be missed by GPs and limits their participation in such processes. ***A letter will be sent to Public Health advising them of this matter.***



5.1.16 As primary record holders, it is good practice for GPs to maintain a database of children who are subject of child protection or child in need processes or who are looked after, and to use this as the basis of the multi-disciplinary meetings. This helps GPs to be confident that they are monitoring each child in their practice list who is vulnerable in this way to ensure their health needs are properly met. It also enables practices to effectively monitor and manage their participation in multi-agency safeguarding processes. At the time of our review however, we found that there was an over reliance on the health visitor to identify children to be discussed at the meetings in all of the practices and to raise each child separately for discussion rather than the practice itself. We are aware that the CCG have been working with a safeguarding and IT working group to identify ways of improving information streams across general practice and in those practices visited we found that GPs have a positive approach to sharing information and the use of the safeguarding node on the electronic patient database as demonstrated by our review of cases and our interviews with GPs. However, there currently remains an over reliance on the community children's health teams to update information on the system.

**(Recommendation 4.6)**

5.1.17 Although the health practitioner at the MASH positively promotes the importance of health information as part of the children's safeguarding process, she is not supported well during annual leave or unplanned sickness. Following safeguarding strategic meetings whilst on duty, the health practitioner routinely 'tasks' other practitioners in health using SystemOne so that they are aware of risk and can take the appropriate action to minimise that risk. When away from her desk however, there is no cover in place to manage the same workload so those SystemOne tasks do not take place. On returning from annual leave for example, the health practitioner is only able to manage her current workload and is not in a position to review strategic meetings that will have taken place during her absence. There is a risk therefore that important information arising from strategic meetings is not fed into other areas of health. The health economy are aware of this and are seeking to address the issue with partner agencies. **(Recommendation 4.8)**

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## 5.2 Governance

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5.2.1 The looked after children designated nurse for safeguarding is currently employed on a fixed term contract. Consideration should be given to funding this important role as a full time post with due consideration given to the practitioners roles and responsibilities reflected in a clear role description. **(Recommendation 5.10)**

5.2.2 A PSHFT safeguarding dashboard maintained by the named nurse for safeguarding children is updated monthly and includes data such as; the total number of children aged under five years who attend PSHFT ED, the number of children aged under five years screened through the child protection register and the number of concern sheets and referrals to children's social care completed by practitioners on the unit. The dashboard also includes a CWILTED analysis of the number of children aged five years and under presenting as trauma cases and the number of CWILTED assessments completed. This is important work to maintain oversight of local trends and the ability of practitioners to recognise risk and record and report accordingly. It does not however, currently detail children and young people aged five years and over who attend the ED. We are aware consideration is underway to better understand the vulnerabilities of this age group.

5.2.3 Peterborough are in the early stages of discussion around the implementation of the national child protection information system (CPIS). This is a national alert system that identifies any children or young people that has a child protection plan in place. This will be a positive development, as it will enable practitioners to easily identify vulnerable children and young people attending the ED.

5.2.4 In the Peterborough MIU, a 0 to 19 years discharge audit dated March 2016 showed that the correct record keeping of logging attendance in the chronology of significant events and that the correct discharge pathway had been chosen stood at 100% compliance. Records are audited routinely where five random cases are examined for compliance with the completion of chronologies prior to discharge so that SystemOne records are complete and inform practitioners of significant events at subsequent attendance.

5.2.5 Peterborough MIU is open from 08:00hrs to 20:00hrs seven days per week. A GP is available to assess more complex cases where required between 12:30hrs and 20:00hrs although we were advised by practitioners that out of hours GPs as provided by CPFT are generally available to offer advice and guidance outside of these hours.

5.2.6 A recent audit during January, February and March 2016 highlighted the increasing number of children aged two years and under who attend the unit. We were advised that the main reason for the increased attendance is because parents and carers are finding it increasingly difficult to book an early appointment at their own GP.

5.2.7 There is good senior management oversight of the health visiting service in Peterborough. This is maintained through regular monitoring of the delivery of the healthy child programme. This consists of data being presented to commissioners on a quarterly basis and by collecting monthly data and through exception reporting. This helps demonstrate whether targets are being achieved.

5.2.8 There is currently no management oversight on safeguarding practice within adult mental health services in Peterborough. We were not aware of any audits being undertaken regarding safeguarding practice and in particular for assessing compliance with practitioners filling out a 'keeping children safe assessment', and for those families not subject to a child protection plan. (**Recommendation 5.11**)

**N.B.** We have since been advised that, '*The safeguarding children team collate all referrals to children's social care throughout the trust, including adult mental health. The team also collate contacts with the team for safeguarding children advice and guidance, by directorate and this has shown a month on month increase in the number of adult facing staff contacting the safeguarding children team for advice about adult service users where there are safeguarding children concerns.*' This information was not made available to us at the time of inspection.

5.2.9 Quality assurance in adult substance misuse services is well developed and provides good oversight of case files where service users have access to vulnerable children and young people. Routine dip sampling of files is undertaken on a regular basis and an audit form is then completed. Comprehensive checks include; ensuring that relevant children's names and addresses are recorded, that all relevant sections of the safeguarding record are complete, that minutes from child protection meetings are contained within the file, that safeguarding information includes information shared with other agencies and that referrals to social care describe key concerns and risks.

5.2.10 The CCG have produced a number of resources to assist GPs to participate fully in all safeguarding threshold activity for children in their patient list with particular needs. For example, an electronic referral 'eCAF' has been developed and is awaiting implementation across the practices in Peterborough and in neighbouring Cambridgeshire. This form is intended to enable GPs to make referrals into the local authority early intervention team where they identify children who would benefit from early help.

The CCG have also developed child in need and child protection case conference report forms held on the electronic patient database for use by GPs. The purpose of these forms is to enable GPs to provide information, in a consistent way across the area, about particular children and their families where a child in need plan is in place. This form has only recently been implemented and so we did not see evidence of its use at this early stage. However, one of the practices we visited told us that their staff were ready to use this template and that they expected it to support effective information exchange with children's social care.

5.2.11 We were told by all three GP practices we visited that monthly multi-disciplinary meetings were held where the needs, progress and continued safety of vulnerable children and their families would be discussed. We are also aware that a general weakness in this oversight of individual cases was highlighted in a recent section 11 audit carried out across the CCG and that it is now subject of performance measurement for GPs. However, the three practices we visited are operating this model to a varying standard. In one practice, safeguarding meetings between GPs and health visitors is well established and where school nurses are often in attendance. In another practice it had been common for the health visitor and practice nurses to attend the meetings and the lead GP had only recently taken an active role. In the third practice, monthly clinical meetings take place where vulnerable children are sometimes discussed with other health professionals. In the latter case, however, safeguarding children was only one of a number of items on the agenda and in one set of meeting minutes we saw there were no vulnerable children discussed during the meeting at all. (**Recommendation 4.7**)

5.2.12 Despite long term attempts the CCG have been unsuccessful in recruiting a successful candidate to the role of named GP. In order to address this, and with NHS England support, the CCG employ a band seven nurse as a named professional for general practice. The practical effect of this is that development and co-ordination work has been able to proceed proactively, at a greater pace and with some clear outputs. For example, the CCG supported GPs in Peterborough and neighbouring Cambridgeshire to carry out their section 11 audits and to identify plans for action to remedy shortfalls, such as the aforementioned multi-disciplinary meetings. Furthermore, resources have been produced to support effective working such as the recently implemented report writing template. In our interviews with practice staff we learned that the support afforded them by the named professional had been valuable. We consider this to be an innovative way of resourcing a key post.

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## 5.3 Training and supervision

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5.3.1 ED practitioners do not have access to formal safeguarding supervision. However, they do have readily available access to the trust safeguarding children team, and can request one-to-one supervision if identified as an individual need. We were informed that if a particular difficult case has been experienced within the department then the safeguarding team will offer group safeguarding supervision where issues can be discussed with peer support and associated learning.

5.3.2 ED practitioners have access to mandatory in house level three safeguarding training which incorporates CSE awareness training. Practitioners also have access to multi-agency level three training provided by Peterborough LSCB, although attendance is not a mandatory requirement.

5.3.3 CAMHS have provided ad-hoc training to the paediatric ward at PSHFT which includes the use of appropriate methods of restraint. This was following a need which was identified by individual practitioners working on the paediatric ward. CAMHS practitioners have also been invited to attend paediatric unit meetings which take place on a bi-monthly basis. This has been used as an opportunity to review cases, share learning and identify future training topics.

5.3.4 In midwifery, although ad-hoc safeguarding advice and guidance is available to staff as required via the named midwife and advanced midwifery practitioners, formal safeguarding supervision within midwifery is lacking. A lack of robust safeguarding supervision is frequently an element of serious case reviews and although specific national models for safeguarding children supervision have not been formulated within health, this is an area for development at Peterborough City Hospital. Community midwives at PSHFT, as caseload holders, would benefit from in depth one-to-one supervision sessions. This would help to ensure a degree of professional challenge in cases where increased support or intervention for vulnerable women is identified and also ensure that potential risk or drift is not overlooked.

Hospital based midwifery staff would benefit from group supervision sessions which would allow a degree of peer support and learning, particularly where staff have been involved in complex cases on a short term basis (**Recommendation 1.9**)

5.3.5 Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). We were advised that midwives at PSHFT fulfil the learning hours required as they attend mandatory safeguarding children training annually and compliance is monitored. Competencies are reportedly in line with the intercollegiate document. However, the training received by midwives is single agency only and does not contain a multi-agency element and therefore training is not fully compliant with the intercollegiate document. This is a missed opportunity to better understand the roles and responsibilities of other agencies involved in safeguarding children work and also promote the principles of working together. (**Recommendation 1.10**)

5.3.6 There is currently little in the way of assessing safeguarding competencies in the midwifery preceptorship programme. Amending the current preceptorship programme to include safeguarding competencies would aid the learning and development of newly qualified midwives and prioritise this essential element of their role at an early stage of their professional career. (**Recommendation 1.11**)

5.3.7 Health visitors attend mandatory level three in-house safeguarding training annually and in-house level three classroom based training every three years. In addition, health visitors have access to a range of training including; maternal mental health, contemporary issues in safeguarding, CSE, FGM and domestic abuse. This is good practice as it is important that practitioners are accessing specialist training relevant to their role in order to ensure that they are up to date in relation to safeguarding children and providing families with appropriate support, guidance and advice.

5.3.8 All health visitors have access to one-to-one safeguarding supervision every three months which is provided by the safeguarding named nurse team in the trust. We saw evidence of discussions at safeguarding supervision sessions being recorded on individual health records. However, documented outcomes and plans following a safeguarding supervision session were not always SMART and did not clearly articulate what was discussed at the meeting, individual practitioner responsibilities and clearly defined timescales. Outcome focused plans need to be documented on the health records in order to review progress and inform on-going practice. ***A letter will be sent to Public Health informing them of this matter***

5.3.9 Cases for safeguarding supervision are routinely identified by the health visitor and discussed during the session. We were further informed that the safeguarding supervisors will also randomly select cases for discussion where practitioners themselves are unable to identify a case for review. This is good practice.

5.3.10 All school nurses receive safeguarding training that meets the requirements of intercollegiate guidance. Newly recruited school nurses are provided with level three training as part of their induction and this is then subject to annual refresher at multi-disciplinary face to face training sessions with colleagues from other parts of CPFT. Shorter, two-hour sessions held throughout the year and termed 'bite-sized' training is provided to staff regarding particular topics which include domestic abuse and CSE.

5.3.11 Safeguarding supervision is well established within the school nurse service. This includes two or three-monthly one-to-one supervision specific safeguarding supervision sessions with a member of the safeguarding team in addition to any ad-hoc supervision as and when required. Each staff member has their own safeguarding supervision file where all sessions are logged and the case discussions are noted for risk factors and protective factors. These notes are then scanned onto the electronic patient records system and the hard copies kept in the staff file where actions are monitored and followed up. An entry is made in the patient's record of the supervision session including the details of the discussion, the analysis of risks and protective factors, the wishes and feelings of the children and young people and the agreed actions for the practitioner. This is good practice as it enables practitioners to be clear about actions they need to take, to understand the rationale for those actions and to create an accountable record of decisions made.

5.3.12 All CAMH staff, including those support staff who do not regularly interact with children and young people receive face to face training in line with intercollegiate guidance. This training is offered on a multi-disciplinary basis across the children's services provided by the CPFT and involves case study and local and national trend analysis. The maintenance of staff knowledge and competence is assured by the trust's 'safeguarding satchel'.

5.3.13 In addition, all CAMH staff (whether clinical or not) are provided with level three training during their induction period which ensure that they are equipped to practice as soon as they begin independent work. All clinicians are also given opportunities to attend multi-agency training. We learned of some 'bite-size', two hour sessions provided by the trust safeguarding team to all practitioners, the most recent of which have been regarding CSE and domestic abuse with a further session planned on conference report writing. This ensures that competence is maintained across the service and enables staff to receive valid training in manageable sessions.

5.3.14 Training and supervision arrangements for the looked after children health team are appropriately in line with intercollegiate guidance with a wide range of supervision arrangements, including access to external supervisors. We saw evidence of good child centred supervision on the health files for looked after children.

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# Recommendations

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- 1. Peterborough and Stamford Hospitals NHS Foundation Trust should:**
  - 1.1 Ensure best practice by ensuring methods used to assist ED practitioners in recording additional important information including details of accompanying adults of children and young people to the unit as well as parental or carer responsibilities are used and are further subject to routine audit.
  - 1.2 Ensure that where practitioners are asking questions of adults attending the ED with young people and young people themselves, regarding access to children's social care, that those questions are recorded along with answers given on patient records.
  - 1.3 Implement methods to ask young people aged between 16 and 18 years if they would prefer to be assessed as a child or adult when receiving care and support within PSHFT ED.
  - 1.4 Maintain managerial oversight of referrals made to inform social care of child safeguarding concerns to ensure those referrals are of the highest quality to inform the decision making process.
  - 1.5 Ensure important questions are asked questions regarding potential and actual domestic abuse are asked at more than one stage during pregnancy and further that those questions are asked alone without the partner being present with the expectant mother at the time of questioning.
  - 1.6 Ensure methods are in place to better safeguard vulnerable children on the maternity unit by strengthening the exit system from the ward.
  - 1.7 Undertake a review of the risk assessment process within midwifery and ensure a more robust and auditable system is in place to assess risk to unborn children and babies and their mothers, particularly in relation to assessing and recording risk of CSE and FGM. This should include practitioner access to, and use of, a formal risk assessment tool.
  - 1.8 Strengthen 'notification of pregnancy' letters from midwifery services to GPs to request relevant safeguarding or concern information.
  - 1.9 Implement formal safeguarding supervision pathways for both community and hospital-based midwifery practitioners.
  - 1.10 Improve midwifery level three safeguarding vulnerable children training to include a multi-agency as per intercollegiate guidance.



- 1.11 Amend the current midwifery preceptorship programme to include understanding and assessment of safeguarding competencies.
  - 1.12 Ensure efforts continue to deploy appropriately trained paediatric nurses within PSHFT ED to ensure appropriate cover according to audited need.
- 2. Cambridgeshire and Peterborough CCG and Lincolnshire Community Health Services NHS Trust should:**
- 2.1 Provide appropriate information to parents, carers and young people that information will be shared with social services and other partners when safeguarding concerns are raised at the MIU.
- 3. Peterborough and Stamford Hospitals NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust should:**
- 3.1 Ensure formal environmental risk assessments are undertaken and recorded when children and young people are placed on a paediatric ward to await mental health assessment. This should include risks posed to other persons located on or visiting the ward at the time
- 4. Cambridgeshire and Peterborough CCG should:**
- 4.1 Ensure discussions held between health visitors and GPs and any actions resultant from those meeting are recorded on client records and health plans.
  - 4.2 Explore and implement methods to improve information sharing between GPs and school nurses regarding vulnerable children and families in Peterborough, including school nurse participation in GP practice meetings.
  - 4.3 The CCG must audit and monitor the quality of referrals made to children's social care by GPs to ensure their quality and effectiveness improves and can better inform the decision making process.
  - 4.4 Ensure GPs are kept informed of the outcomes of referrals made to children's social care so that patient records can be updated accordingly.
  - 4.5 Maintain oversight of the quality of reports submitted by GPs to inform the child protection decision making process and assure themselves that they are of a standardised and effective quality.
  - 4.6 Encourage GPs to identify vulnerable children, young people and families for discussion at multi-disciplinary meetings rather than relying on health visitor services to provide this information.

- 4.7 Review multi-disciplinary meeting practice across GP surgeries and implement better continuity in the way that discussions with midwives, health visitors and school nurses take place to better improve safeguarding information sharing.
- 4.8 Ensure better support to the health practitioner within the MASH so that appropriate cover is provided to the post during sickness and annual leave.

**5. Cambridgeshire and Peterborough NHS Foundation Trust should:**

- 5.1 Ensure measures are in place to provide prioritised CAMH services to looked after children in Peterborough at the earliest opportunity.
- 5.2 Implement best practice methods to ensure an effective perinatal mental health service is in place across Peterborough.
- 5.3 Improve oversight and audit of health and action plans in adult mental health services to ensure they are 'SMART' and include clearly defined actions, timescales and responsible practitioners.
- 5.4 Implement methods to ensure client records are as complete as possible by uploading all referrals made to social services onto client records. This should include any recommended actions following the referral being made.
- 5.5 Improve oversight of and ensure health plans arising from initial and review health assessments are SMART and include clearly defined actions, timescales and responsible practitioners.
- 5.6 Assure themselves that all looked after children, including those older young people, are being appropriately assessed for risk, including the risk of CSE.
- 5.7 Ensure variations seen in growth measurements as part of the health assessment process are appropriately explored and actions recorded.
- 5.8 Ensure all available evidence resources are used, explored and recorded in patient records prior to initial and review health assessments taking place.
- 5.9 Continue consultation and methods to implement a health passport system at the earliest opportunity to better inform care leavers of their personal and family (where known) health histories.
- 5.10 Ensure continuity of roles in LAC health, specifically in relation to safeguarding by giving due consideration to fixed term posts.

5.11 Ensure oversight by way of routine audit of safeguarding best practice in adult mental health.

**6. Peterborough and Stamford Hospitals NHS Foundation Trust and Lincolnshire Community Health Services NHS Trust should:**

6.1 Ensure mechanisms are in place to identify adult attendance at the ED or MIU are notified to school nurse services where those attenders are identified as having undertaken 'risky behaviours' and have parental or carer responsibilities to children and young people.

**7. Lincolnshire Community Health Services NHS Trust should:**

7.1 Implement mechanisms to question and record adult parental or carer responsibilities and sibling details, particularly in the case of adult attenders at Peterborough MIU who have undertaken risk taking behaviours.

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## Next steps

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

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](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.