

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

Children Looked After and Safeguarding

The role of health services in Doncaster

Date of review:	8 th September 2014 – 12 th September 2014
Date of publication:	4 th November 2014
Name(s) of CQC inspector:	Daniel Carrick Lea Pickerill
Provider services included:	Doncaster and Bassetlaw Hospitals NHS Foundation Trust Rotherham, Doncaster and South Humber NHS Foundation Trust
CCGs included:	NHS Doncaster CCG
NHS England area:	North of England
CQC region:	North (East)
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Sue McMillan

Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
The child's journey	8
Early help	8
Children in need	13
Child protection	16
Looked after children	23
Management	25
Leadership & management	25
Governance	26
Training and supervision	28
Recommendations	30
Next steps	32

Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 68 children and young people.

Context of the review

In March 2014 public health England stated that children and young people under the age of 20 years made up 23% of the population in Doncaster with 10.9% of school children being from a minority ethnic group.

The health and wellbeing of children in Doncaster is generally worse than the England average with infant mortality rates similar to the England average. The level of child poverty is worse than the England average with 24.8% of children aged under 16 years living in poverty.

Child and maternal health observatory (ChiMat) data suggests that on the whole, the health and well-being of children in Doncaster is generally worse when compared to the England average. Both the infant mortality rate and the child mortality rate in Doncaster are comparable to the England average.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly worse when compared against the England average. ChiMat reports that in 2013, the overall percentage of all Doncaster's children having MMR vaccinations was similar to the English average and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared to the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2011/12 was significantly better than the England average. The rate of hospital admissions caused by injuries in two age cohorts (children under 14 years of age and young people between the age of 15 and 24 years) was significantly worse when compared to the England average. The rate of hospital admissions for mental health conditions was significantly better than the England average and the rate of hospital admissions as a result of self-harm in 2012/13 was comparable to the England average.

In 2013, the department for education (DfE) reported that Doncaster had 335 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). The Doncaster CCG annual looked after children report states that at the end of March 2014 there were 522 looked after children in Doncaster. The majority of these children were placed in the borough and circa one third of these children were placed outside of the borough. An additional 121 children from other local authorities were reportedly placed within the borough. Of these children, six Initial Health Assessments and 114 Review Health Assessments were completed on behalf of their responsible commissioner.

The majority of Doncaster residents, 97.5% (298,559 residents) are registered with GP practices that are part of the NHS Doncaster Clinical Commissioning Group (CCG). There are some Doncaster residents that are registered with GPs that are a part of further CCGs but these are much lower in number.

Commissioning and planning of most health services for children are carried out by NHS Doncaster CCG and NHS England.

Acute hospital services are provided by Doncaster and Bassetlaw NHS Foundation Trust (DBHFT).

Community based services are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH).

Child and Adolescent Mental Health Services (CAMHS) are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust.

Specialist facilities, such as CAMHS are commissioned by NHS England

The last inspection of health services for Doncaster's children took place in April 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review. The findings from the inspection were:

- The overall effectiveness of the safeguarding services outcome was assessed as adequate.
- The contribution of health agencies to keep children and young people safe outcome was assessed as adequate.
- The overall effectiveness of services for looked after children and young people outcome was assessed as adequate.
- The being healthy outcome was assessed as inadequate.

The report

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

What people told us

We spoke with an expectant mother who is working with the specialist substance misuse community midwife. She told us:

"She got me into rehab and I feel much better for it. She's nice and gives me all the support I need. I'd be lost without her, she does everything."

She went on to tell us: *"I get everything explained to me here (midwifery services) and I've just had a scan and they told me everything I need to know about what's going on."*

We spoke with another expectant mother who uses services provided by the specialist substance abuse community midwife. She told us:

"I couldn't want to have a better person helping me out. She's always there on hand and if I'm worried about something she's there straight away to talk to me. You can tell her anything and everything."

She went on to tell us:

"There's lots going on in my life that is all over the place. When I'm here everything is ordered, it's reliable and makes sense. It makes a change."

Another parent we later spoke with about her experience of midwifery services on the post-natal ward told us:

"Midwives wouldn't listen to me or help me and this was my first baby. I had problems breastfeeding and thought it was my fault. If I could give them a tip it would be to listen to us."

Another expectant mother we spoke with told us:

"I'm never kept waiting here. It's changed a lot since I had my last baby and it's much better. Everyone is so friendly and chatty and I get given all kinds of important information about healthy eating and what I need to do to keep my baby safe. I really enjoy coming here."

One parent we spoke with regarding the child and adolescent mental health service (CAMHS) said:

"We couldn't ask for better. They are always there if we need them and we have never had to wait for an appointment."

We spoke with a young parent who had used the services of the family nurse partnership (FNP). She told us:

"The information they gave me was really useful. They showed me lots of good things, like how to calm the baby down."

We also spoke with a young person about their experience of looked after children (LAC) services. They told us:

"I have no problems in getting any help I need. My nurse is there straight away, I find her really helpful. I am always asked where I want my reviews, I used to have them at school but now have them at the home."

They went on to tell us:

"I have always been given a copy of my health plan and always kept up to date with what is happening. The only help I really needed was around contraception and my nurse gives me advice and takes me to the clinic."

The child's journey

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

1. Early help

1.1 Doncaster CCG are working closely and pro-actively with other multi-agency partners to ensure potential safeguarding issues to children and young people are recognised at an early stage and as such can be managed without the need for referral to children's social care. This includes the commissioning of autism family practitioners to work with young people living with autistic spectrum disorders with a remit to recognise potential risk at an early stage, especially during their transition from children's services to adult. This is seen as good practice.

1.2 RDaSH is pro-active in promoting recognition of child sexual exploitation (CSE) and supporting victims of it, and there is a health professional who works directly in the multi-agency team to identify and work with children and young people at risk of CSE. Young people identified as being at risk of CSE are offered a health needs assessment within two days of the referral being accepted and that assessment will be completed within five days.

1.3 The health professional within the CSE and trafficking team also takes an active role in promoting the importance of recognising and reporting CSE in Doncaster. This includes providing training to multi-disciplinary teams within health, including GPs, contraception and sexual health (CASH) services and school nurses. She also undertakes promotional events as a multi-agency team in the public arena, for example hosting an event at a local ice skating rink. She works closely with the CASH team in outreach, community work with promotional material being placed in 'hot spots' within Doncaster where private enterprise allows, such as fast food establishments.

1.4 Part of the 'early help' strategy in Doncaster is the planned development of a multi-agency safeguarding hub (MASH). The development of the MASH will provide multi-agency screening to ensure timely and necessary interventions and improve the outcomes for vulnerable children.

1.5 Children and young people who attend the emergency department (ED) at Doncaster hospital register with the shared reception area where they are asked to provide full demographic details, including who is accompanying them. The current electronic system does not allow for more than one contact name and address to be recorded, so if the person who has brought the child or young person to the department is different to the adult with parental responsibility there is the opportunity for this to be missed. (**Recommendation 2.1.2**)

1.6 Practitioners complete the safeguarding triage for non-accidental injury for all attendances at the ED of children and young people under 19 years. We were advised that this is mandatory and the patient record cannot be closed unless this has taken place and information recorded. However, the safeguarding questions can be asked at any point during the attendance and in some cases we saw the questions on safeguarding were not asked until the point of discharge. This is not good practice and means that practitioners treating the child or young person are not always being fully informed of risk. DBHFT are aware of this and are working with the software suppliers to effect change. (**Recommendation 2.1.1**)

1.7 ED staff are not routinely using available assessment tools for mental health or alcohol misuse for adults and young people. We examined records of young people under 18 who had attended the ED following alcohol misuse who were treated and discharged without any referrals being made to the local young people's substance misuse team. We were told that there are no referral protocols in place with the young people's service and that they do not routinely attend the department to see young people. This is a missed opportunity to identify young people who may be misusing alcohol and offer early support and advice. (**Recommendation 2.1.8**)

1.8 The paediatric liaison health visitor (PLHV) attends the ED daily between Monday and Friday to collect copies of any referrals to children's social care and details of any attendance where practitioners feel that parents would benefit from extra support. For example, this can include feeding, home safety and the management of childhood illness. This is seen as good practice.

1.9 The PLHV also reviews a computer system generated report of all attendances of children and young people that includes details of the reason and outcome of the attendance. This acts as a safety mechanism to ensure that appropriate action and information sharing about families requiring extra support has taken place. However, we are unsure about the robustness of ED practitioners in exploring circumstances surrounding attendances to ED and there is an over-reliance on the work of the PLHV. No cases were copied to the PLHV despite many being identified as appropriate during case sampling as part of this review. (**Recommendation 2.1.4**)

1.10 From records seen, there is an over reliance on the description of events provided by parents to ED staff and a lack of inquisitive inquiry by staff to explore further circumstances surrounding the accident or reason for attendance. We examined one case where there was a discrepancy between the description of events provided to the out of hours GP and at triage and the events recorded by the medical staff. This discrepancy had not been commented on by any clinician and neither had it been referred to children's social care or highlighted to the PLHV.

1.11 Children and young people waiting to be seen in the ED are provided a separate area away from the general waiting area and are then seen and treated in a paediatric consultation room.

1.12 We were advised that ED staff are not able to roster a paediatric trained nurse on all shifts within the department and to mitigate potential risk have arranged for a number of adult ED nurses to undertake a paediatric module at a local university. We were advised that it is expected that all staff will have completed this training by April 2015. In addition, adult ED staff have undertaken intermediate paediatric life support training and we heard how paediatric staff from the ward will attend if a critically sick child is brought in to the ED.

1.13 Children and young people seated in the paediatric waiting area within the ED cannot readily be observed by ED practitioners who are not be able to quickly identify a deteriorating sick child or observe the interaction between children and adults accompanying them to the department. We did not see any signs within the waiting area reminding parents to seek urgent assistance if they felt their child's medical condition was deteriorating. This is seen as a risk, especially as in some cases seen children were waiting for long periods of time before being seen. In one case seen, an infant with a head injury who had been vomiting waited for an extended period of time before being assessed. (**Recommendation 2.1.7**)

1.14 Midwifery risk assessment takes place at the booking of pregnancies. Expectant mothers can book their pregnancy children's centres around Doncaster, with their GP, on the maternity unit or at home if required, although this is not routine practice. Pregnant mothers are given opportunity to speak with midwifery staff alone at any time during pregnancy so that issues around potential domestic violence can be discussed.

1.15 The number of teenage pregnancies in Doncaster has fallen during recent years. However, the teenage pregnancy midwife is increasingly challenged by client beliefs from an increasingly diverse community. This includes, for example, attitudes to teenage pregnancy, smoking and breast feeding.

1.16 Community midwives spoke of close working relationships with health visitors in Doncaster. Health visitors are increasingly conducting joint home visits with community midwives at 36 weeks pregnancy, especially if the expectant mother or unborn child is the subject of child protection measures. Both disciplines meet regularly to discuss cases.

1.17 Some community midwives remain based in GP surgeries but the majority are now based at children's centres around Doncaster with easy access provided to expectant mothers. Midwives spoke of generally good working relationships with GPs; they are routinely visiting GP practices to peruse newly booked expectant mother case files.

1.18 The 'call to action' strategy to increase health visitor numbers has been considered successful in Doncaster. There is a 'grow your own' process whereby newly appointed staff members are supported by a mentorship programme specifically aimed at providing them with the tools and experience to work effectively in their chosen specialism.

1.19 Health visitors are commissioned to deliver the core Healthy Child Programme and to date have made good progress in meeting performance indicators.

1.20 There have been negotiations with NHS England to provide health visitors with flexibility to improve the offer to include a new initiative the 'promotional guide' conversation which is centred on building relationships. This approach includes an antenatal visit and a second visit when the baby is between four and eight weeks old. Early feedback is very positive with parents reporting high levels of satisfaction with the continuity of health visitor, and we saw one person comment that they "left feeling confident" and generally had an improved understanding on the development of the baby's brain.

1.21 Health visitors are being trained in perinatal mental health and more training is being sourced. This will provide women with perinatal concern with an enhanced service.

1.22 Childhood obesity is a significant challenge for families in Doncaster. Practitioners have recently been trained in the HENRY programme (Health, exercise, nutrition in the early years) and this is proving popular with families. It was piloted in the areas of highest need within Doncaster and a good indicator of this having a positive impact is that families remain engaged with the programme.

1.23 Within health visiting, one case examined demonstrated how health visitors effectively tracked and engaged with a family who had repeated changes of address within Doncaster.

A health visitor carried out a new birth visit to mother L who said that she was a single mother, living with her own mother and brother. There were some initial concerns about domestic violence with her previous partner. Although this was never substantiated, a referral was made to children's social care who decided no further action was necessary.

Records show that L moved home and arrangements were made for the nursery nurse from the new health visitor team to carry out a transfer-in visit. Records further show that a male was now living in the household who is described as the father to the baby. There were no concerns identified about the development of the baby.

A member of the health visiting team returned to carry out a development review and records indicate that this was failed visit. The health visitor followed this up with the GP who subsequently found out that the family had moved area again.

The family have been visited again as part of the transfer-in. Records demonstrated the concerns expressed by the CASH service but there are no health issues for the child and the father is currently living abroad.

1.24 Young people accessing contraception and sexual health services (CASH) provided by RDaSH are safeguarded well. We examined evidence of health practitioners being inquisitive and using adaptive styles of work when they suspected young people may be subject to personal circumstances that might make them the subject of safeguarding concerns. This is seen as good work.

In one case examined we saw how the CASH practitioner suspected issues of domestic violence toward a young client. The nurse used her initiative to speak with the young person alone regarding her suspicions, but with the young person's permission, she also spoke with other family members. Consent was also granted by the young person for the nurse to contact CAMHS, the school nursing service and to also make a referral to children's social care.

We examined evidence of the comprehensive recording of the nurses concerns, of inter-agency information sharing and acknowledgement of facts and further, tenacity on the part of the CASH nurse to ensure her referral had been both received and was being attended to. Details of other family members, including siblings and the alleged perpetrator of the domestic violence, were also clearly recorded. We also saw that the referral made to children's social care was clear and detailed in highlighting the nurses concerns but could have contained more information about perceived risk.

Although the referral was not deemed as meeting the criteria for child protection interventions being put in place, the CASH nurse in this instance had demonstrated and recorded how she had followed both laid down procedures for safeguarding vulnerable young people, but also in managing the case in the way that she did she also gained the trust of the young person concerned who evidenced her own understanding of the situation and as such went on to satisfy health professionals of her own safety.

1.25 CASH services have recently undergone structural changes in service provision with services now being universally provided for young people up to age 18 with a separate team to provide services to adults. Throughout the changes, we were told that the quality of service provision to young clients has remained a priority with many young people not noticing any difference in the way they access services.

1.26 All CASH services provision to young people is via 'drop in' access with extended opening hours during week days. All drop-in services are qualified nurse led. Outreach services are also provided from children's centres in North, East and South Doncaster.

1.27 Doncaster drug and alcohol services for adults over 18 are provided by RDaSH. Clients can either self-refer or be referred from other health and statutory agencies, including from the justice system. A single gateway assesses all referrals made, and for those clients that require more intensive work or where safeguarding concerns are identified, key workers are allocated from the central treatment base. This means that more senior and experienced staff work with the most vulnerable families.

2. Children in need

2.1 We heard how children and young people who attend the ED following self-harm or in need of support for mental health concerns are now able to access good support from CAMHS. Children and young people are usually referred for CAMHS assessment once they are medically stable and are often accommodated on either the paediatric ward if they are under 16 or on the MAU if they are over 16 years.

2.2 However, ED practitioners are not always sharing information with CAMHS on the attendance if the young person is already known to their service. In the case of one young person (who was waiting to attend their first appointment with a local counselling service, and attended the department following an incident of self-harm) a decision was made not to refer for CAMHS assessment and details of the attendance was not appropriately shared. This issue was addressed during the review and the young person has now been given an initial appointment with CAMHS and the information on the ED attendance included in her notes.

2.3 Children, young people and families have open access to an effective CAMH service. All statutory agencies are able to refer families for support and a recent initiative has started where young people can self-refer via a 'walk in clinic' on a Monday.

2.4 In CAMHS, referrals are considered daily and children, young people and families are seen quickly. All urgent referrals are seen within 24 hours and routine referrals are offered appointments within four weeks. Effective arrangements ensure that referrals received for families that are inappropriate for CAMHS interventions but where the support of the integrated family support team would be more beneficial are discussed at a weekly joint meeting. This means that families are offered the most appropriate support at the earliest opportunity.

2.5 Young people who require in-patient admission for their mental health needs are usually accommodated at the Becton hospital in Sheffield. There have been no recent admissions of a child under 16 into an adult ward within Doncaster.

2.6 Children and young people who do not attend CAMHS appointments are not discharged without appropriate safeguarding in place. Practitioners are expected to discuss the decision with senior clinicians and the referrer is always notified of any non-attendance and also a decision to discharge. The safety of any child is paramount and influences the decision to discharge or continue to try and engage the family in treatment.

2.7 Midwifery cases examined highlighted that there was a good information sharing processes in place for domestic violence and substance misuse, which includes appropriate plans being put in place to ensure staff were aware of recognised risks. Where referrals were made to social services those referrals seen were mostly of adequate quality but did not always highlight perceived risks.

(Recommendation 4.3)

2.8 Community midwives are supported by specialist community practitioners in both teenage pregnancy and substance misuse. CSE is considered high on the agenda in Doncaster and midwives have all received training on how to recognise and report concerns.

2.9 There is no provision within midwifery for specialist domestic violence support. However, in records examined and in discussion with staff members we saw that staff recognise and record incidences of domestic violence and relationships where it might be hidden and then make appropriate referrals via multi-agency risk assessment conferences (MARACs). These are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies.

2.10 We saw how safeguarding children is a priority for practitioners working with adults within substance misuse services. The initial assessments of risk identify and record children resident in client households as well as any children a client may have that no longer lives with them. Risk assessments are regularly updated to reflect significant change and as a minimum every three months.

2.11 We also saw how clients are provided with safe storage boxes for medicine to help minimise the risk of children ingesting substances by mistake. Safety plans seen include how to protect the children when the adult is using substances. The expectation is that where risk is identified to children, this is discussed at each consultation and records reviewed confirmed that this is happening. Practitioners told us, "We work hard to support our service users so that they can be safe around their children."

2.12 Practitioners from adult substance misuse services are expected to attend multi-agency meetings to safeguard and protect children living in households of adult clients. We saw evidence of regular attendance at team around the child meetings (TAC), children in need (CiN) and child protection meetings. Where practitioners were unable to attend, they submitted reports that were also shared with the trusts safeguarding team.

2.13 Practitioners demonstrated a good awareness on the potential impact of parental mental health and behaviours on the wellbeing of the child and in some cases seen made strenuous effort to try and identify children in households in difficult circumstances.

A practitioner from the adult mental health access team attended a consultation with a male, X, who had been referred to the service from his GP. During the consultation X became agitated and very aggressive and refused to disclose details of any children either with whom he lived or had contact. The practitioner completed the initial mental health needs assessment and risk assessment and returned to the office. Concerned about the behaviour of X and the impact of this behaviour on any children he may be in contact with, the practitioner contacted children's social care to ask if X was known to them. Children's social care declined to share any information with adult mental health services.

The adult mental health practitioner contacted colleagues in substance misuse and probation to find out if they were aware of any children who may be at risk. Records held by substance misuse showed that X did have children but the information on their living arrangements and parental responsibility was outdated.

The remainder of the safeguarding elements of the needs assessment and risk assessment were completed from this third party information and the practitioner made a referral to children's social care.

2.14 School nurse practitioners have developed innovative methods to engage well with children and young people in Doncaster. For example, school nurse drop-in services were being increasingly poorly attended by young people. As a result of this, and in consultation with young people, an electronic online 'e' clinic has been developed. The website contains advice for young people that can be accessed at any time. There is also the option for young people to 'instant message' a school nurse between the hours of five and seven pm, Monday to Friday. We were told that this service is very well used. This is good and innovative practice.

2.15 Young people are also actively involved in school nurse led focus groups in relation to the development of service delivery. One of the results from this service includes the decision to ensure school nurses undertake their duties in blue nurse uniform so they can be readily identified by children and young people accessing their services.

2.16 Secondary school pupils are provided with a regular 'clinic in a box' service. Presentations are provided by school nurses during school lunchtimes and include information around sexual health and healthy eating, but the team can also provide on-the-spot chlamydia testing, pregnancy testing and the provision of condoms. 'Clinic in a box' roadshows take place on a weekly basis and can include input from other public health partners, including the child sexual exploitation and trafficking service.

2.17 Families of concern are discussed at monthly meetings between GP practices and health visitors. These discussions facilitate a more informed and collaborative approach to supporting vulnerability. More recently, a small number of GP practices have withdrawn from these meetings due to the lack of financial support from the CCG and we are unsure as to how these practices have implemented alternative arrangements to share information on vulnerable families.

3. Child protection

3.1 There is no electronic flag on the EDs computer system to alert practitioners if a child or young person has a child protection plan in place. There is a paper based list of names that is available to staff in the department but this is not regularly updated to reflect those children and young people who may no longer be subject to child protection measures. (**Recommendation 2.1.5**)

3.2 Adults who attend ED following incidents of self-harm, mental health concerns, domestic violence or substance misuse are not routinely asked whether there are children in the family at triage. In all but one of the cases examined, we saw no evidence of adults being asked if the patient had children at home or had caring responsibilities.

3.3 Copies of referrals to children's social care are copied to paediatric liaison and to the trust's safeguarding team. We heard how no referrals had been made to children's social care over the weekend, following concerns about the attendance of an adult with concerning behaviour. This is a missed opportunity to identify children who may need to be protected from potentially harmful behaviours of the adults who care for them. (**Recommendation 2.1.3**)

3.4 In some cases seen, children and young people were leaving the ED before being assessed for treatment. We are aware of the Trust policy in relation to children and young people not leaving the department before being assessed, but we were further advised that it has been custom and practice within the department that the nurse in charge would be informed of any children that leave the department without being seen and that they would follow it up with the family by way of a telephone call. This is seen as poor practice and presents as a risk to potentially vulnerable children and young people. (**Recommendation 2.1.6**)

3.5 Risks associated with paternal health and lifestyle choices that may have an impact on the unborn or new-born children are routinely checked and recorded at booking in with midwifery services. We saw that partner details are recorded at booking-in where not provided and when the details are either unknown or are refused, midwives record as such and then try again to obtain those details at a later stage if necessary.

3.6 Midwifery professionals prioritise attendance at child protection conferences and team around the child meetings and as such are able to attend the majority of meetings for which they receive timely notification. We were advised that midwives in Doncaster engage at child protection meetings as non-passive participants and will actively challenge and advise where considered necessary. This was evidenced in one case we examined where despite the original referral being refused by social services, a second, more clearly articulated referral was made which was formally accepted for consideration.

3.7 Referrals to children's social care are not always robust in the way that they identify risk to either the child or young person or to other, hidden members of the family. Where risk might be noted by health professionals it is not well articulated on those referrals.

3.8 Most health professionals we spoke with told us that when they make referrals, the timeliness of responses by local authority safeguarding teams is generally good and has been improving. On most occasions they are kept informed of the outcomes of any referrals made. However, this is not the case across all health services in Doncaster. We are aware that Doncaster CCG is working pro-actively with multi-agency partners to ensure information is shared in a timely manner to ensure children and young people in Doncaster are appropriately safeguarded.

3.9 Doncaster CCG engages actively and well with other multi-agency professionals by placing a health professional within the social care referral team. This placement is seen by healthcare professionals in Doncaster as a positive way of supporting them when making referrals to social care. It is also a positive conduit for multi-agency information sharing to further safeguard vulnerable children and young people.

3.10 In one case examined within the school nursing team, we saw how the risk of children being witness to non-physical domestic violence and possible physical abuse on the young person from a male outside of the family home was mentioned but was not clearly articulated to social services. There was also a younger sibling identified within the family home. Those risks were not then conveyed to other multi-agency partners who could then undertake their own investigations. This case has now been taken forward for further review. (**Recommendation 4.1 and 4.3**)

3.11 School nurses work from two hubs in Doncaster and provide community based health services to children and young people aged between five and 19 years. The intervention role of school nurses in child protection cases is assessed and decisions made as to the amount of interventions they might have to provide as a part of the child protection process. For example, if a school nurse undertakes no current health interventions with the child they are not expected to attend all child protection meetings.

3.12 This way of working frees up school nurses, who already carry large numbers of child protection cases on their caseload to undertake other, pro-active health promotion work. However, they are expected to liaise with the chair of the conference to confirm their non-attendance and they will provide a report accordingly. The child's record is then be updated to show the reason for their non-attendance.

3.13 This process is relatively new and as yet no audit has been undertaken to quality assure the process.

3.14 Findings from previous multi-agency inspections had resulted in the recruitment of a health liaison post to work with social care and police practitioners to facilitate professional understanding of process and risk when responding to requests for intervention and early assessment. Changes within the structure of children's social care have meant that the post holder is now working with health practitioners to increase their understanding of thresholds and how to increase the effectiveness of their referrals.

3.15 There are too many incidences of health visitors failing to challenge and respond to failed visits to vulnerable new families. Although we saw evidence of health visitors discussing their concerns with the allocated social worker or in some cases the GP, we did not see evidence of any escalation to the trust's named nurse which is part of the trust's policy. **(Recommendation 3.4)**

3.16 Attendance at key child protection and core meetings is a priority for health visitors. Reports for conferences are clear and articulate well the impact of parental behaviour on the wellbeing and safety of children. In all cases we reviewed, reports had been shared with the parents prior to the conference taking place.

3.17 Most health needs assessments seen that were completed by health visitors were comprehensive and child focussed. In some records we saw evidence of clear planning with goal orientated objectives. However, in other cases we saw evidence of drift in progress with health visitors demonstrating a lack of professional curiosity in challenging parents, leading to possible missed opportunities to intervene and safeguard children earlier. **(Recommendation 4.2)**

3.18 Health visitors are using professional judgement as to when and how chronologies of significant events in vulnerable families should be created. In most records the chronologies that we saw were not in place and this made reviewing significant events and progress difficult to evaluate and understand. **(Recommendation 3.4)**

3.19 Health visitors we spoke to were generally enthusiastic about the 'strengthening families' model used by children's social care and described it as providing clarity around the strengths within a family and also the risk. Some health visitors described how when using this model, conference chairs were much more confident in holding practitioners and families to account.

3.20 We saw some cases where health visitors were aware of extreme vulnerability in expectant mothers where plans were being discussed to either remove their babies at birth or where this was a strong possibility, and they had made the decision not to carry out an antenatal visit. This is not part of the trust's policy and does not reflect the service's approach to supporting expectant mothers both before and after birth. We examined the notes of another health visitor who had visited such a case and the recording evidences a sympathetic and supportive consultation, demonstrating an inconsistency in service provision. **(Recommendation 3.4)**

3.21 CASH nurses are using an electronic patient record system to record all interventions with children and young people. This allows them to access the records of other multi-agency health professionals who also use the same system. Children and young people who are made the subject of child protection measures are clearly flagged on the system so that practitioners are prompted to further interrogate the system for relevant information which might inform their decision making process.

3.22 CASH practitioners are not routinely informed of the outcomes of referrals made to children's social care. Further, they are not routinely invited to attend child protection conferences nor are they advised if a child or young person is made subject of protection measures. CASH practitioners 'chase' referrals made to inform their work with young people and will routinely attend case conferences and meetings when invited to do so.

3.23 Where substance misuse practitioners identify concerns about the safety of a child they routinely refer them to Doncaster children's social care. Referrals made are also copied to the trust's safeguarding team. We saw how referrals to children's social care are sometimes not accepted despite practitioners feeling that the threshold for intervention is met. Referrals were not always articulating well the risk to the child or young person, however. Escalation processes are in place and from cases examined we saw that there is appropriate use of advice and support from the trusts safeguarding team. (**Recommendation 4.3**)

3.24 The substance misuse service use an electronic patient record and staff members were enthusiastic about the benefits of using the system, including the ability to easily share information, where appropriate, with colleagues in primary care, health visiting and school nursing. However, we saw some records that were incomplete because of a delay in uploading scanned documentation, including minutes from core groups and child protection conferences. We were told that the current delay has been reduced to approximately five weeks. This delay means that practitioners working with vulnerable clients may not have access to the most up to date information. (**Recommendation 3.5**)

3.25 Perinatal mental health services work well for those expectant women who require support for mild to moderate mental health needs. They are prioritised within the increased access to psychological treatment service (IAPT) and the adult mental health access team are able to offer rapid assessment. The pathway is less clear for those expectant women or women who require urgent crisis intervention post-delivery, and there is ongoing discussion across health providers on how best to respond to their needs.

A is a young woman transferred to adult substance misuse services from the young person's service. She was previously looked after by the local authority and is well known to local services. A has a history of poor engagement with professionals and frequently did not attend appointments or collect her prescriptions. A exhibits symptoms of mental illness. However, because of her failure to engage with mental health professionals there is no formal diagnosis of this.

A disclosed to her substance misuse worker that she had started a relationship with another service user and that she was pregnant. The worker made a referral to children's social care based on A's unassessed mental health, her failure to engage constructively with substance misuse services, frequent non-attendance at appointments and failure to routinely collect prescribed medication.

When A was in her third trimester, children's social care arranged a pre-birth planning meeting. The substance misuse worker attended along with midwifery staff although A and her partner did not attend. A decision was made that the case did not meet the threshold for child protection. Notes on the case record indicate that the substance misuse team was unhappy with this so took advice from the trust's safeguarding team. The advice that followed was to formally write to the children's social care manager.

A short while later the decision was made to progress concerns and an initial child protection conference was called with the resulting decision to place the unborn on a child protection plan under the category of neglect.

Baby B was born and subsequently discharged home with parents and core groups arranged. Substance misuse workers continued to attend key meetings and relayed their concerns that A was still not engaging with services effectively, missing appointments and not collecting prescriptions.

Practitioners completed review risk assessment paperwork regularly and scored A as moderate risk.

Minutes of core groups from 2014 were not scanned on the service's database.

3.26 The substance misuse team work creatively to try and maintain engagement with service users and demonstrate flexibility in appointments and locations, using texting and phone calls to remind people about their appointments.

Z is a young woman with three children; one with special needs. Z has accessed support from substance misuse services intermittently over a number of years and more recently after a long spell of abstinence. Following the latest relapse, children's social care had placed two of the children with family members and they could only return to live in the family home on the condition that Z engaged with substance misuse services.

Professionals were supporting Z and her family through child in need and little progress had been made. Records examined showed intermittent engagement with services with many missed appointments with substance misuse services and poor school attendance by children.

Regular core groups continued without any improvement being noted and at a later child in need meeting, a suggestion was made to step down family support to team around the child. Health and education professionals disagreed with the suggestion as they felt it unsafe. However, the case was then closed.

Z continued to miss appointments and as a result of this the substance misuse service issued her a letter discharging her from the service.

Shortly afterwards concerns were raised by a community support police officer about the welfare of the children and a referral was made to children's social care. An initial care conference took place which substance misuse services attended. It was decided at the meeting that the threshold for intervention was met and the children were protected with a child protection plan being put in place.

3.27 CAMHS are good advocates for the children and young people they support. Clinicians and managers have used the LSCB resolution protocol to good effect and effectively safeguarded children and young people as a result.

Y is a young person aged 15 who in an inpatient at a local in-patient CAMHS facility.

In February 2014, children's social care stated that they were closing the case as Y was accommodated in a safe place with appropriate supervision. They also did not consider that they had a role in her care at that time. A suggestion was made that Y could be discharged to her previous home address.

CAMHS advocated vigorously for Y and challenged the local authority through the LSCB resolution policy for professional disagreement. Resolution was obtained. Y now has an allocated social worker who is actively involved and a placement has been found into which Y is happy to move.

3.28 Adult mental health workers carry out joint visits, where appropriate, with children's social care to assess and plan how best to support vulnerable families.

3.29 Relapse indicators, either as part of a service user's wellness recovery action plan or the crises contingency plan, are not routinely shared with professionals involved in supporting a family where a parent or adult in the household has mental health needs. This means that professionals may not always recognise deterioration in the adult's mental health and there may be a delay in seeking assistance and therefore a delay in safeguarding children in the family and protecting them from the impact of the adult's mental health. **(Recommendation 4.1)**

3.30 There was a recent incident where a service user with children was discharged from in-patient care without notifying the child's social worker. This was not reported as a significant event. However, managers from both clinical areas are working together to look at how to improve communication and prevent a recurrence.

G is a female with a diagnosis of bipolar disorder. The adult mental health service is aware of relapse indicators and earlier this year G contacted services and started to display signs that she was becoming unwell.

Adult mental health practitioners tried to engage G and persuade her to access treatment without success. Eventually the AMHP made a visit to the home and was refused access. The AMHP contacted children's social care and a second joint visit was made to carry out a mental health act assessment.

A decision was made to admit G under the MHA and whilst these arrangements were being made, the attendance of the children's social worker allowed simultaneous assessment and planning to ensure that the children in the family were appropriately safeguarded.

3.31 We observed significant drift in agencies effectively supporting vulnerable families at the most appropriate level, predominantly as a consequence of lack of shared understanding of professional risk across agencies, sharing of information, professional curiosity and on some occasions weak referrals to children's social care.

4. Looked after children

4.1 Doncaster CCG recognises the pressures in ensuring the timeliness of health assessments for children and young people placed out-of-area. Although it has been difficult to influence both the timeliness and quality of those health assessments, continuing liaison with health professionals out-of-area ensures that, where possible, health assessments are completed in a timely fashion.

4.2 The provision of a bespoke care leaver health service for Doncaster young people has been a key target for the specialist LAC nurse team since the Integrated Safeguarding and Looked After Inspection in 2011. Support is now provided to care leavers up to age 19 and this further supports transition into adulthood.

4.3 Children and young people looked after are able to access effective support for their emotional health and wellbeing from a dedicated CAMH service. Any professional working with a child looked after can refer to the service. Initial assessment includes a consultation with all professionals and adults involved in the child's life and a plan is created on how best to meet the child's emotional needs. We heard how this is often through supporting foster carers, residential home staff and education staff in their interventions with these vulnerable children.

4.4 CAMHs CLA do work directly with children and they described how, although there is no dedicated CAMHS consultant psychiatry or psychology support, clinicians are supportive and respond quickly to requests for advice and assistance.

4.5 Health summaries are now created at the point of a child or young person becoming looked after and populated throughout their time in care. These documents are becoming increasingly meaningful and informal discussions are taking place with young people on the format of these important documents.

4.6 Initial health assessments examined do not maximise this important opportunity to comprehensively and holistically assess a child or young person's emotional and physical health at the time they come into care. There is little evidence that consideration is paid on the impact of the parent's health on the current and future health of the child. The lack of parental health information is a repeated theme in CLAS reviews and young people repeatedly tell us how important this information is to them. (**Recommendation 3.1**)

Child M is a 6 year old child who became looked after earlier this year. The initial health assessment has minimal detail on the health of her parents though does make reference to alcohol and substance misuse. Within the assessment there is reference to M poor sleeping and describing 'night terrors' and to possible global development delay.

The health care plan does not consider whether the impact of maternal alcohol abuse may contribute to development delay as a consequence of foetal alcohol syndrome. There is also no reference to seeking specialist CAMHS support for this vulnerable child to explore the reasons for her poor sleeping and 'night terrors.'

4.7 On most cases seen, young people were signing as consenting to both the initial health and review health assessments or their verbal consent was documented by the practitioner undertaking the assessment. Clearly explaining the implications of providing consent for multi-agency professionals to share important information about them encourages young people to engage in their assessment and for them to start to take responsibility for their own health.

4.8 We saw no evidence of strength and difficulty questionnaires (SDQs) being used to inform health reviews for children and young people. Current arrangements mean that only carers are asked to complete the SDQ and not the young people themselves. This is a missed opportunity to engage young people (who are competent and able to undertake their completion) in the assessment process so that they might identify for themselves their emotional health and wellbeing needs and then go on to monitor their own progress. (**Recommendation 3.2**)

4.9 We saw significant improvement in the quality of review health assessments and health care plans since our previous multi-agency inspection. Assessments seen clearly evidenced the voice of the child. In one assessment examined, there is evidence of discussion with a young person about permission to share information and negotiation about with whom they wanted the school nurse to discuss the issues they had raised. This was respected.

Management

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

5.1 Leadership and management

5.1.1 DBHFT is without a named nurse for safeguarding. The former post holder retired in June 2014 and we were advised that the post remains vacant. There are two specialist band six nurses covering some of the activities of the named nurse post. Whilst the basic requirements of supervision and training are being provided, the influence of a named nurse to provide leadership in safeguarding children across the organisation is missing.

5.1.2 Monthly pregnancy liaison meetings have recently been implemented in Doncaster to provide information and advice to multi-agency professionals to ensure pregnant women are enabled to access services at the right stage of their pregnancy. Focus will be provided to pregnant women about whom professionals may have concerns including drug and alcohol misuse, domestic violence, mental health and those subject to or previously subject to child protection measures.

5.1.3 Due to the fact that only one meeting had been held at the time of our review, we were not able to test the effectiveness of these meetings. Staff members we did speak with were hopeful the process will strengthen and develop communication and shared working practices; thus better supporting vulnerable pregnant women and their unborn children.

5.1.4 Mental health issues amongst pregnant women in Doncaster are seen as a risk, with a suggested figure of at least 1,256 women living with some degree of mental illness out of 4,000 pregnancies. With this in mind, pilot work was undertaken known as the Doncaster perinatal mental health advisory pilot, with the objective to establish the demand for a perinatal mental health service in Doncaster. The performance of the pilot work is now being considered by commissioners.

5.1.5 Health visiting is now provided as part of the early years (0-5yrs) pathway across the borough of Doncaster. Services are still commissioned by NHS England with close liaison with commissioners in waiting ready for the transfer of services to public health England.

5.1.6 The child sexual exploitation and trafficking annual report of 2014 recommends continued education delivery to children and young people, parents, carers and professionals, continued partnership working to deliver outreach work and the development of a pathway for referral directly to the health lead in the CSE team. It also recommends obtaining service user comments and views about the quality of service that they receive to help shape future service delivery. Proactive work around the important issue of CSE in Doncaster is seen as a positive step in protecting vulnerable children and young people.

5.1.7 GP involvement in the MARAC process is underdeveloped. This means that GPs are often unaware of families discussed at MARAC and therefore cannot use this information as part of a holistic assessment during patient consultation.
(Recommendation 1.1)

5.2 Governance

5.2.1 There is no scheduled formal opportunity to share learning on safeguarding children practice within the ED to drive a programme of continuous quality improvement. Comments on the quality of referrals to children's social care and the outcomes of those referrals, where known, are fed back to practitioners by paediatric liaison or a member of the safeguarding team on an individual basis via senior nurses. Similarly, where the PLHV identifies good practice or missed opportunities to help a family or protect a child her findings are fed back on an ad-hoc, informal basis. **(Recommendation 2.1.4)**

5.2.2 Although supervision is available to practitioners, this is limited because of time constraints and from the records seen, this consists mainly of management supervision rather than being based around case-based safeguarding children practice.

5.2.3 Ad-hoc audit to interrogate practitioner compliance with trust policy is hindered by the decision to withdraw the 'e' audit function from lead nurses in the ED.

5.2.4 The introduction of the 'e' CAF (common assessment framework) is seen as a continuing difficulty in midwifery services. Paper copies of the CAF are no longer accepted and staff members are still waiting for training to be provided so they can effectively partake in the CAF process. This is despite the system being in place for over 12 months. Currently some staff members complete a paper CAF which they then take to a suitably trained colleague for transfer to an 'e' CAF.
(Recommendation 4.5)

5.2.5 CAMHS is delivered and monitored through a rigorous set of key performance indicators which include timely access to services and successful transition into adult services for those young people that are considered suitable for targeted help.

5.2.6 RDaSH have no central arrangements in place to monitor practitioner attendance at child protection meetings; instead this is a personal responsibility, with practitioners expected to notify their team manager or the safeguarding team if they are unable to attend a key meeting. There is an expectation that practitioners will, as a minimum, submit a report for conferences and these are copied to the trust's safeguarding team.

5.2.7 Adults who require treatment for moderate mental health needs are referred to Access which is the single gateway to secondary adult mental health services. The Access Team are able to respond quickly to referrals and carry out an initial mental health needs assessment and a formal risk assessment which inform a risk management plan. They demonstrate a flexible and responsive approach to the assessment, often carrying these out at a community base or in the client's own home if this is safe and is their preferred option.

5.2.8 Safeguarding concerns and risk to children is an integral part of both these assessments. Practitioners are expected to record details of any safeguarding concerns and also the names and demographic dates of any children in the household or with whom the client may have contact. The current IT recording system does not facilitate the routine recording of children. This means that the details of children who may need to be safeguarded are not routinely recorded and stored in a systematic way. (**Recommendation 3.3**)

5.2.9 The named GP for safeguarding now sits on the recently convened bi-monthly safeguarding development group. The groups aim is to examine recommendations made by 'lessons learned reviews' and serious case reviews (SCR) and ensure they are implemented effectively and appropriately monitored within primary care.

5.2.10 The named GP for safeguarding also sits on the national children and young people's health outcome forum. The forum reviews outcomes for children and young people across all areas. From this the named GP has access to a national picture which he can bring back to Doncaster to inform local arrangements and inform development. From October 2014 the named GP will also sit on the LSCB and will represent GPs in a provider capacity to present the views of Doncaster GPs and also feedback information to them. This is seen as good practice.

5.2.11 GP practices we visited were using codes on their IT systems to alert practitioners to children and young people with child protection plans in place, children looked after and other vulnerable families. We saw how practitioners were making entries onto a patient's record when they were discussed at the local children in families (CIF) meeting.

5.2.12 A practice nurse in one GP practice we visited has responsibility for reading through all initial health assessments and health plans for children looked after to identify any action for primary care, although we heard how GPs are not routinely asked to contribute to initial and review health assessments. GPs may hold information that would inform assessments and it would be good practice to elicit their input as primary record holders. (**Recommendation 3.1**)

5.3 Training and supervision

5.3.1 CASH health professionals are all trained to level three safeguarding in line with intercollegiate guidance. This is seen as good practice. Training is also provided in a multi-agency setting and safeguarding supervision takes place in bi-monthly group meetings with ad-hoc one-to-one supervision in between as required by nurses or senior management. Supervision is provided by the named nurse for safeguarding.

5.3.2 DBHFT are working hard to ensure all practitioners working in the ED are safeguarding trained to level three. The clinical educator and safeguarding team have developed a schedule for delivery of the existing one day level three safeguarding 'Working Together' training course specifically for ED practitioners who are being allocated to set training days to ensure attendance. A programme of updates has also been developed which includes learning on topical issues including domestic violence and child sexual exploitation and trafficking.

5.3.3 We were advised by the community midwifery team that annual safeguarding update training is provided to all staff working within the team. Training includes updates on the mental capacity act, CSE and trafficking, female genital mutilation and the MARAC referral process.

5.3.4 Where case supervision has taken place, the outcomes of that supervision are not routinely recorded on electronic patient records. Where we were advised that case supervision had taken place, this could not be evidenced and we could not examine any evidence of suggested actions being put in place as a result.
(Recommendation 4.4)

5.3.5 Safeguarding supervision within midwifery is varied. We were advised that supervision for community midwives is provided every three months or ad-hoc according to practitioner needs in-between. Community midwifery supervision is provided on a one-to-one basis or in groups with peer support. Actions resulting from supervision are recorded individually in patient notes and on a separate office based record.

5.3.6 Safeguarding supervision for ward-based midwives is not so structured, with the results of any supervision taking place not being routinely recorded. We are aware this is currently the subject of an ongoing action plan. **(Recommendation 4.4)**

5.3.7 Practitioners working in adult substance misuse are expected to attend a minimum of level three safeguarding children training. Robust arrangements are in place to ensure practitioners attend the right level through electronic staff profiling. Attendance is monitored through the electronic staff record system.

5.3.8 Supervision in child safeguarding is an integral part of clinical supervision within adult substance misuse services, although the trust policy is that where an individual client is discussed in supervision, an entry should be made on their patient record. We did not see any evidence on the files that we examined of this policy being followed. (**Recommendation 4.4**)

5.3.9 Practitioners in CAMHS manage their own electronic training record which is populated with mandatory training as agreed against their job profile. CAMHS practitioners are expected to attend Level 3 training; either the trust's in house training or the local LSCB multi-agency training.

5.3.10 Supervision in safeguarding children within CAMHS is currently delivered by the trust's named nurse for Doncaster. However, due to capacity issues, the supervision policy has been amended and a number of key staff have been identified to be trained in delivering safeguarding supervision. The current proposal is for the named nurse to deliver this training which is not best practice.

5.3.11 The named nurse for Doncaster in RDaSH meets with new CAMHS practitioners personally to discuss with their previous experience in safeguarding children and works with them to develop an individual training plan to ensure that they are competent and confident in supporting these vulnerable families.

5.3.12 The health visiting service is on trajectory to recruit to vacancies. A robust preceptorship is in place to help identify the individual learning needs of practitioners new into post with an agreed individual learning plan. This includes learning around writing reports for conference, working with vulnerable families and attending child conference meetings.

5.3.13 Effective supervision is supporting health visitors to work pro-actively with vulnerable families and safeguard children. Reference to supervision is contained within the patient record and copies of the supervision discussion and plan is uploaded. This is best practice.

5.3.14 Access to safeguarding supervision for GPs was seen to be open and accessible, provided either by the named GP for safeguarding or by named nurses for safeguarding according to individual GP preferences.

5.3.15 Protected safeguarding update training is provided annually across two sessions which allows GPs to attend either, again according to personal preference. This is 'protected time' training and will include national updates on best practice. We were advised that 95% of Doncaster GPs routinely attend this training.

5.3.16 The designated doctor for safeguarding (a consultant community paediatrician) takes an active role in safeguarding training as provided to GPs at level three, presenting for example, general medical council guidance on neglect and early help.

Recommendations

1. Doncaster CCG should:

- 1.1 Ensure that General Practitioners are effectively involved in the local MARAC arrangements.

2. Doncaster & Bassetlaw Hospitals NHS Foundation Trust should:

- 2.1 Review the arrangements for safeguarding children and young people in the Emergency Department to ensure that:
 - 2.1.1 The safeguarding assessment is carried out at the earliest opportunity.
 - 2.1.2 Arrangements are in place to record the details of adults with parental responsibility as well as the details of adults who accompany the child where this may be different.
 - 2.1.3 Improve the identification and recording of children and young people in households of adults who present at ED with risk taking behaviours or with mental health concerns.
 - 2.1.4 Provide a routine opportunity to review and improve safeguarding practice and share learning within the ED.
 - 2.1.5 Implement a process to ensure that the list of children and young people who have a child protection plan in place is regularly updated.
 - 2.1.6 Implement a policy safeguarding the health and wellbeing of children and young people who leave the ED without being assessed or seen by a health practitioner.
 - 2.1.7 Review the arrangements for observing children within the paediatric ED waiting area, to include using signage to alert families to seek assistance if their child deteriorates.
 - 2.1.8 Work with providers of young people's alcohol and substance misuse support services to enable the sharing of information to facilitate early referrals and support where this is appropriate.

3. Rotherham, Doncaster & South Humber NHS Foundation Trust should:

- 3.1. Work with partners to improve the quality of initial health assessments for children looked after to ensure they reflect health information from all professionals involved in the child or young person's care as well as parent's health histories.
- 3.2. Evidence measures put in place to influence the completion and sharing of information contained in SDQ's so that they can be better used to inform health assessments, including the role of young people in completing their own assessments.
- 3.3. Ensure there is a systematic way of recording details of children and young people in households of clients with mental health concerns.
- 3.4. Ensure that health visitors and school nurses are compliant with trust policies and guidance on completion of chronologies, failed visits by health visitors and carrying out antenatal visits on vulnerable families.
- 3.5. Ensure that arrangements are in place to upload hard copy documentation onto patient records without unnecessary delay.

4. Doncaster CCG, Doncaster Bassetlaw Hospitals NHS Foundation Trust & Rotherham, Doncaster & South Humber NHS Foundation Trust should:

- 4.1. Ensure that health practitioners are trained in, and fully understand, local information sharing protocols to ensure that information is shared appropriately to protect and support vulnerable families and children.
- 4.2. Review arrangements for training and supervision to ensure that the role of health practitioners in demonstrating professional curiosity and appropriate challenge to families is understood and demonstrated in practice.
- 4.3. Ensure that referrals to children's social care contain an analysis and articulate well the risk to the child or young person to aid colleagues in children's social care in their decision making.
- 4.4. Ensure notes of issues discussed and decisions made in supervision are contained within the patient record.
- 4.5. Expedite the training of professionals involved in the CAF.

Next steps

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

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