

# NOT SEEN, NOT HEARD



A review of the arrangements  
for child safeguarding and  
health care for looked after  
children in England

JULY 2016

## Our purpose

**The Care Quality Commission is the independent regulator of health and adult social care in England.** We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

## Our values

**Excellence** – being a high-performing organisation

**Caring** – treating everyone with dignity and respect

**Integrity** – doing the right thing

**Teamwork** – learning from each other to be the best we can

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# Foreword

Children and young people have the right to be protected from abuse and exploitation and to have their health and welfare safeguarded. Yet in 2013, UNICEF reported that the UK ranks 16th out of the 29 most advanced economies in the world in terms of the overall wellbeing of their children (including material wellbeing, health, education, behaviours and risk, and housing and environment). Although the trajectory is that of improvement, children's health services still have a way to go to ensure that the care they provide is improving children's lives and keeping them safe.

There is unwarranted variation across England in the quality of the arrangements in health services for child safeguarding and for looked after children. These are some of society's most vulnerable children. Over the last 40 years we have seen a plethora of reports providing lessons to be learned from scandals and serious case reviews and an abundance of guidance that describes the elements that contribute to effective safeguarding systems and what children say matters most to them. The gaps are well documented, so why haven't they been addressed?

Children and young people need to be listened to, and need to feel that those looking after them actually care about them. In the majority of cases, individual healthcare staff demonstrate passion and determination in their work to keep children safe. However, the structures and systems to support them are not always in place. From workforce planning, training and supervision, to the use of technology to improve data sharing, to working

effectively together across health, education, social care and justice – many areas are still not getting it right for children.

As an organisation, we recognise the importance of high-quality joined-up care, even before a child is born, as an integral part of the care people should receive throughout their childhood and into their adult life. We inspect children's services to assess the effectiveness of arrangements in health for safeguarding and for looked after children. We are committed to encouraging the improvements needed to ensure that children and young people are kept safe and are supported to achieve their best health and wellbeing potential.

This report shares what we found, including where there are concerns, but also champions what can be achieved when commissioners and providers understand the needs of children and young people, and work together with them and other agencies to ensure their services are making a difference.

Children must be put at the heart of how services are designed and delivered. Their needs must be seen and their voices must be heard. Health services and their staff need to work more effectively together to start closing the gaps in the arrangements in the very services that are there to keep children and young people safe and thriving. No child should be left behind.

**David Behan**

Chief Executive  
Care Quality Commission



# Summary

**Children and young people in care, and those with safeguarding concerns, remain some of the most vulnerable in our society. Yet not all get the help they need when and where they need it.**

The Care Quality Commission (CQC) has been reviewing the health care aspects of children's services in England, under Section 48 of the Health and Social Care Act, since September 2013. The 'Children Looked After and Safeguarding' (CLAS) in-depth inspections assess how health services in a local authority area work together to provide early help to children in need, improve the health and wellbeing of looked after children, and identify and protect children who are at risk of harm. In this report, we analyse the findings of our inspections and focus on the experiences of children to see whether services make a difference to them, and we make recommendations for improvement.

When health and safeguarding systems fail, the voice of the child has almost invariably been lost. Two thirds of the children we spoke to on our inspections said they did not feel involved in their care and therefore did not see the point in accessing the care and support they needed. Healthcare providers are required to involve children in their care, yet were rarely able to

demonstrate how they achieved this, or how they engaged children in the design, delivery or improvement of their services. Where children were meaningfully engaged with, it was done at every level, from being involved in planning their own care to contributing to the design of services to better serve children's needs.

The NSPCC advocates that listening to children improves their emotional, mental and physical health. The only way to check whether services are improving outcomes relating to health and wellbeing is to measure them. The review found that when providers and commissioners monitored appropriate outcomes, they knew exactly what was making a difference in their area and could focus their efforts and resources where it mattered most. However, the extent to which such outcomes were being monitored and used effectively to improve care varied significantly.

With the right questions and support, children's services can discover the risks and harms that threaten many children, including those from parental ill-health, sexual exploitation and female genital mutilation. The extent of these problems is still largely unknown, and how well children are being protected from them, even less so. Most areas are not yet effectively identifying and protecting children at risk of these hidden harms.

The review also found that the needs of children in transition are overlooked. This includes those

transitioning from children's to adult health services and looked after children who are moving area or leaving care. The experiences of these young people are poor as health services are failing to help them prepare for the next stage in their life. Access to the emotional and mental health support they need remains a significant concern as the provision of child and adolescent mental health services (CAMHS) is not meeting their needs. Where services were effectively helping children who need these services, they worked together to produce meaningful care plans for the future, enabled access to the right specialists and were flexible around age and geographical boundaries to ensure that support did not end abruptly.

The solutions to these complex problems do not lie solely with individuals. Many highly motivated and skilled staff working with children want to make a lasting difference. However, it is often obstacles within the system that prevent progress being made. Health professionals are in a strong position to address children's health and welfare needs and identify safeguarding concerns, but no single person can have a full picture of a child's circumstances. To keep children safe, health staff must share appropriate information in a timely way.

Children's inspectors found that health professionals have improved how they assess risk and recognise safeguarding concerns. However, this review identified problems in how those risks are then shared with different services. Practitioners frequently did not articulate their views of the risks to the child or set out what they expect from the referral – leaving the receiving team unclear of the concerns. As a result, actions were delayed or failed to take place at all. This was prevalent across the health system, but particularly in primary and emergency care settings.

The review found that the quality of information sharing was strengthened by robust partnership working, supported by investing in long-standing, trusting relationships across agencies. It was also supported by compatible electronic systems that flagged concerns about vulnerable children, as well as shared policies and pathways that helped staff to be clear on what should be done, when, where and by whom, and reduced variation in practice. This highlights the need for system-wide collaboration and investment in compatible electronic systems that flag concerns nationally.

Ensuring that these systems are in place and working effectively across the entire health system requires strong oversight, governance and leadership. CQC has found that across all sectors the quality of leadership closely correlates with the overall quality of a service, and children's services were no exception. Given the challenges in promoting and protecting the welfare of all children, and the difficult financial context, increased resources cannot be the only solution. Areas with good leadership worked creatively to ensure their services made the most of their capacity, anticipated gaps and ensured that the right staff, training, supervision and skill mix were in place.

There is unwarranted variation in child safeguarding arrangements and provision for the health and welfare of looked after children in England. This report shares and celebrates examples of innovative and outstanding care to demonstrate what is possible and intends to be a resource in order to drive improvement. It also makes recommendations for how commissioners, providers and frontline healthcare professionals can strive towards protecting and promoting the health and welfare of children.

# CQC's key recommendations

## 1. Children and young people must have a voice

Listening to children is the paramount safeguarding activity. All healthcare providers should engage children at each stage of their care planning in order to help them be involved in, and take ownership of, their own treatment and care. Providers should also seek children's views on what needs to be done to improve the services they use. This includes ensuring that children with complex and severe developmental, physical, emotional and mental health needs also have their views heard and represented.

## 2. The focus must be on outcomes

Care providers and commissioners should substantially shift their focus towards achieving better outcomes for children. All services providing health care need to work collaboratively with children to determine locally-relevant ways to measure outcomes to regularly evaluate the impact they are having on the children who use their services. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and to inform how resources are allocated and services are planned. Health assessments and care plans should also be focused on outcomes and be regularly reviewed to ensure that progress is being made towards goals that have been set jointly with children themselves.

## 3. More must be done to identify children at risk of harm

The risks to many children are not always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms. Services should significantly improve how 'Think Family' practice

is embedded in all adult services, particularly in adult mental health. They should also support staff in improving how they identify, protect and support children at risk of child sexual exploitation and female genital mutilation. More also needs to be done to recognise and protect children at risk of new and emerging harms such as trafficking and radicalisation.

## 4. Children and young people must have access to the emotional and mental health support they need

Children's experiences of transitions in health are unacceptably poor. Significant improvements need to be made in how young people experience transitions in health services, especially as they leave paediatric care and enter adult mental health and substance misuse services. Commissioners and providers of services should ensure that looked after children who are moved out of an area have arrangements for continuity of health reviews and have priority to continue to access health services that they were previously receiving, particularly emotional and mental health support. They should also ensure appropriate support and services for those who are leaving care during this often vulnerable time in their lives. Access to mental health support and treatment for all children must be addressed as a priority, especially in CAMHS.

**"I'm not a case; I'm not a piece of paper. I'm a human. I need you to see that if you're going to help me."**

**A recent care leaver, The Who Cares? Trust**



# Introduction

**It is everyone's responsibility to safeguard children.<sup>a</sup> Although local authorities have overarching responsibility, every organisation and person who comes into contact with a child has a role to play.<sup>1</sup>**

This includes staff in health services who are in a strong position to address children's health and welfare needs and safeguarding concerns. However, no single person can have a full picture of a child's circumstances and therefore services have to work closely together to ensure that children are kept safe.

Society has changed dramatically over the last 50 years, with leaps in technology and increased global mobility presenting new challenges. Children are groomed for sexual exploitation and radicalisation on social media, and young people from certain communities can be at risk of trafficking and female genital mutilation. The number of children identified as having been abused or exploited is only the tip of the iceberg – many more are suffering in silence.<sup>2</sup>

As new risks emerge and more children are identified as being in need because of abuse or

neglect, it is more crucial than ever that staff across health and social care, education, the police and the justice system all work together.

One of the earliest pieces of safeguarding legislation introduced in the UK was the Health and Morals of Apprentices Act 1802, which prevented children working in mills and factories at night and for longer than 12 hours a day.<sup>3</sup> Almost two centuries later, the Children Act 1989 gave every child the right to protection from abuse and exploitation and to safeguarding of their welfare.<sup>4</sup> Over the last 40 years there has been a plethora of reports containing lessons to be learned from scandals and serious case reviews, of guidance describing what elements contribute to effective safeguarding systems and of what children say matters most to them.<sup>5,6,7</sup> But where are we now?

Over the last two years, the Care Quality Commission (CQC) has reviewed the effectiveness of arrangements for safeguarding and looked after children in health services in England, under Section 48 of the Health and Social Care Act 2008. CQC assesses how health services in a local authority area work together to provide early help to children in need, improve the health and wellbeing of looked after children, and identify and protect children at risk of harm. The focus is on the experiences of children and how services make a difference to them.

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a. In this report a child is defined as anyone who has not yet reached their 18th birthday. 'Children' therefore refers throughout to 'children and young people'.



The Children Looked After and Safeguarding (CLAS) reviews involve in-depth inspections of the arrangements in primary care services, acute hospitals, mental health services (including child and adolescent mental health services (CAMHS)) and community services (including health visiting, school nursing, sexual health and substance misuse services).

In order to build on existing knowledge about what makes care effective for looked after children and in child safeguarding, and what barriers prevent children from getting the care they need, the findings of the review have been analysed and common themes identified. Although the findings are specific to how services are working together in health care, most issues identified are very relevant to other sectors, including children's social care, education and the police.

This report gives an overview of the findings, celebrates and shares good practice and makes recommendations on what needs to be done differently to keep children and young people safe.

## How we carried out this review

We carried out extensive qualitative analysis of the 50 reports written by CQC's Children's Services Inspection team from September 2013 to December 2015, while focusing on the recurring themes within them (the list of reports included in the analysis is in appendix A). The coding framework used to identify these themes was developed from the 'lines of enquiry' used when reviewing health services in local authorities. Themes were added to the framework where the analysis highlighted a need for further detail. The findings formed the evidence for the report and are presented in footnotes. It is important to note that local authorities were selected for earlier inspections based on risk, so this analysis may reflect a selection bias. We therefore do not present quantitative data as percentages because of this, but also because we could not assume that if a report did not comment on an issue (such as female genital mutilation) there was an absence of work in that particular area.

## Focus group work

The identified common themes and findings were discussed with the following groups of people:

- A focus group with senior leaders in child safeguarding and looked after children involved in health care in England.
- An expert advisory group (see appendix B).
- Two voice sessions with recent care leavers from The Who Cares? Trust.
- A focus group comprising inspectors from CQC's specialist Children's Services Inspection team.

The remit of these reviews is extensive, so these discussions helped to focus on the key issues and identify the legislative and political context as well as the priorities and emphasis of the main findings in this report. The expert advisory group comprised a broad range of stakeholders including commissioners, providers, frontline healthcare professionals, designated and named professionals, representatives from other sectors including Ofsted, the Department for Education, Department of Health and voluntary sector organisations that represent children. The voice sessions were run with recent care leavers from The Who Cares? Trust to capture their views and experiences on being in and leaving the care system.

## Who this report is for

This report has been written primarily for those who design, run and work for children's health services, but is also relevant to other sectors. This includes senior managers in NHS England, the Department of Health, Department for Education and Ofsted, local authority chief executives, directors of children's services and chairs of local safeguarding children boards (LSCB). It is also important for senior managers within organisations that commission and provide services for children and families, including social workers and professionals from health services, adult services, the police, education, youth justice services and the voluntary and community sector who have contact with children and families. All health professionals should read the

findings and follow the recommendations so that they can best respond to children's needs. We have also published **key points from the review** specifically for children and young people, as well as a **video** that highlights some of the key findings and recommendations.

As well as sharing what CQC found from the review, this report is intended to be a resource to drive improvement. We include many examples of good and innovative practice to highlight and celebrate what can be achieved. After reading this report, we invite readers to complete the reflection template (appendix C) to consider what you have learned, identify additional learning needs and make an action plan for how this will help you to change your practice in future.

## 1

## The child's voice: the silence is deafening

**When health and safeguarding systems fail, it is often because the voice of the child has not been heard.<sup>1</sup>**

The United Nations Convention on the Rights of the Child (UNCRC, 1989) protects the right of children and young people to be involved in all decisions that affect their lives.<sup>8</sup>

Looked after children in care, as well as those subject to child protection processes, often feel powerless. Children want to be respected, involved in decisions and plans, and informed of the outcomes of assessments and decisions that affect them.<sup>7</sup> This empowers them and gives them confidence and competence. The extent to which children are listened to significantly influences how safe and happy they feel.<sup>9</sup>

The silence, however, is deafening. The review found that children were often not involved in decisions about their care and their views were not represented, such as in case conferences. The majority of children that the inspectors spoke with said they did not feel involved in their care.<sup>b</sup> This led to care plans that were impersonal and contained only basic information. Children said

that missing this vital opportunity to engage with them meant they did not see the point in accessing the care and support they need.

### LISTENING TO AND ENGAGING CHILDREN

In Salford, services were taking strides to improve how they listened to and engaged children at multiple levels. Frontline staff in Salford Royal NHS Foundation Trust were holistic in their assessment of children and young people, capturing their version of events and wishes, and including a comprehensive picture of what life was like at home. The quality of health reports to child protection case conferences was good. They demonstrated clear analysis of risk and protective factors, and priority was given to reflecting the voice and experience of the child.

The trust had set up a group to seek feedback from young people and their families attending hospital. Action was also being taken in community health services, such as the development of 'Talking Mats' and employing new methods for engaging young people, especially those with communication difficulties.

Services in Salford developed an extensive range of **useful resources** on capturing the child's voice in a number of settings including the Common Assessment Framework (CAF).

b. Across the 50 reports, we analysed quotes from children to see whether or not they perceived their voice was heard in services. Of the 69 quotes that mentioned voice or involvement, 26 were positive and 43 quotes were negative about this.

Providers of care are required to involve children in their care, yet they were rarely able to demonstrate how they achieved this, or how they engaged them in the design, delivery or improvement of their services.

Where services engaged meaningfully with children, it was done at every level of their care. Children were involved in planning their own health and treatment, were included in child safeguarding procedures and their views were fed back and informed improvement of services to better meet children's needs. This included children with complex communication needs, particularly those with multiple physical health problems or severe learning disabilities.

**“They just say the same things about visiting a dentist or optician every year even though my optician has said I don't need to go for two years. The medical still says I have to go every year just because I'm in care so I feel it's a waste of time.”**

**A young person in care  
(taken from a CLAS report)**

### IMPROVING ENGAGEMENT WITH HEALTH ASSESSMENTS

The designated nurse for looked after children in Solihull successfully engaged with young people who had entered care at a later age or had been resistant to accepting support in the past. Her team developed a 'decliner pathway' to improve engagement with those who had previously been hard to reach. Using different strategies to listen to their needs, the team improved engagement for this group of young people with their health assessments, from 79% to 93% in one year.<sup>10</sup>

**“I could have gone so far in life if I had the opportunity to deal with my abuse as a child. I wish someone would have listened. I seemed articulate, OK, I ticked the boxes, so they moved me along. I seemed fine. You go into the job because you care but along the line it goes a bit wrong. Don't let it. If I was your child or your niece, how would you find out how I really was? Talk to me like that, talk to me like you actually care.”**

**A recent care leaver, The Who Cares? Trust**

### MEETING THE NEEDS OF A CHILD WITH A LEARNING DISABILITY

In Cheshire West and Cheshire, a child protection plan for a child with a learning disability and health needs was tailored to the needs of the mother, as she also had a learning disability that affected her ability to meet the child's needs effectively. The plan was in an easy-to-read format to help build her understanding of what was expected of her. Her capacity to meet her child's development needs was improved considerably by developing a range of visual cues, which supported her to ensure safe routines.

## RECOMMENDATIONS

Listening to children is essential to effective safeguarding. All healthcare providers should engage children at each stage of planning their care in order to help them be involved in, and take ownership of, their own treatment and care.

In practice this means:

- All health staff seek, hear and act on the voice of the child. They should involve children at each stage of their health care planning, and listen and respond to their views about what is important to them.
- All providers and local authorities empower children in meaningful ways to feed back on their experiences of care, with a particular emphasis on how the service is helping to improve their health and wellbeing.
- All children are involved in giving feedback on and co-designing their local services, ensuring they are as accessible and relevant as possible.
- All practitioners, providers and commissioners listen to the children who do not necessarily have a voice, including those with complex and severe developmental, physical, emotional and mental health needs.
- CQC continues to seek and report on the experiences and views of children who use health services as part of our single and joint-agency inspections.

## 2

## The 'so what' factor: improving outcomes for children



**Despite improvements in child health in the last 40 years, children in England have poorer health and wellbeing outcomes than those in comparable countries.<sup>11</sup>**

The only way to check whether services are improving children's health and welfare is to measure the associated outcomes. The review found that outcomes relating to children's health and wellbeing are not consistently being monitored in children's health services. Where this was being done well, providers and commissioners were able to demonstrate that they knew exactly what was making a difference in their area and could focus their efforts and resources where it mattered most. The outcomes that they measured also considered the child's family.

In the worst examples, providers failed to define and monitor meaningful outcomes for children at every stage – from identifying early needs and the effectiveness of safeguarding arrangements, to the health and wellbeing of looked after children and children leaving care.

The variation in how services look at outcomes for children is unacceptable. Most CLAS reviews made recommendations that related to improving

how outcomes for children are monitored.<sup>c</sup>

Limited reporting about needs, outcomes and gaps in services for children – particularly those who are looked after – means that providers and commissioners are not informed when planning or improving the care they deliver.

**“I slept through my therapy sessions for three and a half years. I went because if I didn't go, she would have told my foster parents. She woke me up when the time was up and I left. The professionals should have met up to check if it was working for me. It was a waste of time for everyone.”**

**A recent care leaver, The Who Cares? Trust**

### Early intervention

The care that a child receives during their earliest years, even before they are born, is critical to their future health and wellbeing.<sup>12</sup> A child is considered to be 'in need' if they are unlikely to reach or maintain a reasonable level of health or development, or their health or development will be significantly impaired without the provision of services, or if the child is disabled.<sup>4</sup>

c. There were 75 recommendations related to outcomes across 36 of the 50 reports. They varied between one mention per report, to five mentions in one report.

## A GOOD RANGE OF EARLY HELP SERVICES

Vulnerable children and families in Gloucestershire had access to a range of early help services that were delivering positive outcomes. For example:

- A substance misuse parenting group was delivering sessions on parenting, healthy eating, play/interaction skills and behaviour management.
- A support and education group was addressing attachment issues for parents and young children.
- A programme was set up to support children experiencing, or at risk of, chronic neglect due to a combination of substance misuse, poor mental health and/or domestic abuse.
- A practitioners' advice line and foster carer drop in sessions were available to discuss mental health issues.

To improve outcomes for these vulnerable children, their needs must be identified and addressed early. The review found a worrying loss of focus in recognising children in need early on. Specifically, there was a gap for those identified as needing further help but who did not meet the threshold for child protection. Information is not routinely collected on this group of children, and as a result, the scale of the problem – and whether services are improving it – is unknown. It can only be inferred from the increasing prevalence of abuse and neglect that it is not being prevented sooner.<sup>2</sup> These children are not being adequately recognised or supported by health services.

The review found that midwives played an important role in identifying and supporting vulnerable women in antenatal and postnatal services, including teenage parents. Early intervention programmes were also essential to continue the support after birth. Where this was being done effectively, there was a range of early help services, all of which kept children's outcomes at the focus of how they plan, deliver and review care.

## A PROACTIVE EARLY HELP STRATEGY

In Middlesbrough, children, young people and families who were not making sufficient progress in early intervention programmes were discussed at regular multi-agency forums. These were made up of senior staff from agencies across the partnership (including Children's Social Care, CAMHS, Sure Start Children's Centres, Integrated Youth Support Service, Parenting Services and Neighbourhood safety teams) and provided specialist targeted support, advice and consultation to practitioners. They were identifying trends and emerging issues with more challenging families to achieve positive outcomes through joint initiatives. Outcomes had been identified for children and young people as part of their Early Help Strategy, and were being used to measure progress.

## Using meaningful care planning to improve outcomes for looked after children

Looked after children often enter care with a worse level of health than their peers. They are more likely to have mental health issues, emotional disorders, hyperactivity conditions and autistic spectrum disorders. For example, 45% of looked after children have mental health disorders – rising to 72% for those in residential care – compared with 10% of the general population aged five to 15.<sup>13</sup> They leave care with increased risks of substance misuse, mental health problems, homelessness and offending. Their educational and employment achievements are significantly less, with 41% of 19-year-old care leavers not in education, employment or training (NEET) in 2013/14, compared with 15% for all 19-year-olds.<sup>14</sup>

**“I just don't see the point of the health reviews, same routine and don't see any difference.”**

**A young person in care**

In recognition of these inequities, guidance states that every looked after child should have a health plan describing how their identified needs will be addressed to improve their health outcomes.<sup>15</sup> The number of looked after children with up-to-date health checks has steadily increased nationally (88.4% in 2014 compared with 76.8% in 2011).<sup>16</sup> However, this review found that the quality of health planning was often poor, particularly in setting objectives and measuring outcomes.

All children in care should be involved in prompt, high-quality health assessments, supported by 'SMART' (specific, measurable, achievable, realistic and timely) health plans that are regularly reviewed. The outcomes should be tracked over time to ensure that services are supporting children to achieve better physical and mental wellbeing.<sup>15</sup> Where this was done well, children were empowered to take ownership of their health plan. However, health assessments were not 'SMART' in half of CLAS reports, indicating that many areas did not routinely set goals or measure outcomes for individual looked after children.<sup>d</sup>

### A LACK OF SMART PLANNING LEADING TO POOR CARE PLANS

In one area, we found examples of initial health assessments and associated plans to be extremely poor, lacking depth and exploration of emotional health and wellbeing. Some were significantly overdue. Maternal and paternal health histories were not consistently gathered and the health plans did not contain SMART objectives. Staff were therefore unable to identify existing and potential health needs and plan for the future for these very vulnerable children and young people.

d. 24 of 50 reports specifically noted concerns that health assessments were not 'SMART'.

## Improving emotional health and wellbeing outcomes for looked after children

Emotional health and wellbeing are key contributors to improved outcomes, including better learning and achievement, as well as to the longer-term potential of young people as they transition into adulthood.<sup>17</sup>

In March 2015, the Department for Education and Department of Health updated statutory guidance on promoting the health and wellbeing of looked after children.<sup>15</sup> This outlines the requirement of local authorities to use the strengths and difficulties questionnaire (SDQ), which is a screening tool that offers measures of wellbeing and resilience and enables young people to give their view on how they feel and the progress they are making towards their own goals.

SDQs are used to monitor the emotional health of looked after children aged five to 16 at a national level. In 2015, there were 36,140 children in this age range in England who had been looked after for at least 12 months. Of these children, 72% had a SDQ assessment.<sup>18</sup> Half had a score that was borderline or a cause for concern.<sup>e</sup>

The CLAS reviews paint a far worse picture. SDQs were being used in a meaningful way in only a small minority of areas.<sup>f</sup> The vast majority were not routinely using SDQ scores to inform health assessments or reviews, to appropriately flag concerns or to trigger a more in-depth assessment.

e. A score of 0-13 is normal, 14-16 is borderline and 17-40 is a cause for concern.

f. Of 38 reports that commented on the quality of SDQ assessments, 33 noted that they were not being used appropriately, at all or in a way that informed health reviews in a meaningful way. Five noted them as being used effectively to inform health reviews.



### NOT USING SDQS TO THEIR MAXIMUM POTENTIAL

In one area, SDQs were sent out to foster carers but young people were not routinely asked to complete their own. This was a missed opportunity for those young people to contribute to the assessment and planning of their emotional health and wellbeing.

In another area, there was a protocol for moderate to high scores in SDQs to be reviewed, but no arrangements to monitor this or to collate outcomes to ensure that children received the right services to meet their needs.

Where services were using SDQs effectively, they were:

- Documenting scores in health assessments and reviews (particularly if they were done by social care staff) and ensuring they informed children's plans and goals.
- Using them appropriately as a screening tool, rather than replacing a full mental health assessment where needed.
- Ensuring those with abnormal scores (i.e. 14 and above) were reviewed by specialist professionals, for a more in-depth assessment.
- Following up and tracking subsequent scores to show outcomes of interventions.

## RECOMMENDATIONS

Care providers need to substantially shift their focus towards monitoring outcomes for children. Each part of the system, at each level, has a vital contribution to make.

In practice this means:

- Health services prioritise meeting the needs of children who would benefit from help and support early on, including those who do not meet the threshold for child protection proceedings, but have still been identified as benefiting from further support.
- Health assessments and reviews in all settings follow the Department of Health's guidance to ensure they are focused on action and outcomes for children.
- Screening tools for emotional health and wellbeing, such as strength and difficulties questionnaires (SDQs), are completed annually for every child in care, meaningfully contribute to their health reviews, and are routinely monitored to inform the impact of interventions. Those with abnormal scores are reviewed by an appropriate mental health specialist.
- All health services work collaboratively with children to determine locally-relevant outcome measures, in order to regularly evaluate the impact they are having. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and inform resource allocation and service planning.

## 3

## Quality of information sharing in multi-agency working

Sharing information is vital to safeguarding and promoting the welfare of children. Poor information sharing is repeatedly identified in serious case reviews (SCRs) as contributing to the deaths or serious injuries of children.<sup>19</sup> To keep children safe it is essential that health and social care staff and local agencies share appropriate information in a timely way and challenge partner agencies to work effectively with them.

The review found that health professionals have improved how they assess risk and recognise safeguarding concerns in children. However, we identified problems in how those risks are then shared with different services. The quality of referrals and reports varied considerably, particularly to multi-agency safeguarding hubs (MASH), child and adolescent mental health services (CAMHS) and contraception and sexual health services (CASH).

Practitioners frequently did not articulate their views on the risks to the child and did not set out what they expected from the referral – leaving the receiving team unclear of the concerns. For example, health professionals communicated specific details about the child's health, but often failed to give a holistic picture of the child's circumstances. As a result, actions were either delayed or failed to take place at all. These issues were particularly apparent where referrals had been made from general practice and A&E departments to social care.

### VARIABLE PRACTICE UNDERMINING EFFECTIVE REFERRALS

In one area, the CLAS report outlined significant concerns about how health practitioners across services made referrals to children's social care. Highly variable approaches were being used within and across health services, undermining the effectiveness of safeguarding arrangements. This made it difficult for operational managers to put in place effective quality assurance and governance processes to drive improvement or ensure sustainable consistency.

The referrals that inspectors saw were of poor quality. They did not routinely provide a clear rationale for the referral, articulate the risk of harm to the child, set out the expected outcome or demonstrate the use of threshold guidance.

There was little guidance on how to make safeguarding and child protection referrals. Although a referral template was available, referrers could choose not to use it, and most had not. The result was a system that did not support health practitioners in making quality referrals that would facilitate good decision-making in children's social care.

## Accident and emergency (A&E)

A&E departments and minor injury units did not consistently record key information in line with NICE guidelines.<sup>20</sup> There was a lack of effective documentation in many areas, with some common gaps.<sup>9</sup> These included:

- Documenting the exact nature of the relationship of the accompanying adult, or about their caring responsibilities.
- Capturing the child's own account of what happened, and where possible, independent of their carer.
- Identifying and documenting risks specifically in the 16-18 years age group.

The review identified examples of poor quality referrals where the risks to the child were not clearly expressed in the referring documentation, despite evidence in the notes that a thorough risk assessment had been made.

## Primary care

The contribution made by primary care services to child protection cases was inconsistent, with the majority of areas needing to strengthen arrangements.<sup>h</sup> In many cases there had been no GP contribution at all. Where GPs had been involved, the information submitted about the child's health was frequently too basic. GPs are often in the unique position of knowing the child and their family for many years and can make significant contributions to the safeguarding process.

The most common factors for the lack of GP engagement were:

- Lack of awareness of responsibilities in contributing to child protection cases. Some GPs also lacked confidence in understanding the differing thresholds and procedures for children in need, child protection and looked after children.

g. 16 of 50 reports contained negative comments about documentation within A&E departments.

h. Of the 45 reports that mentioned GP contribution to child protection case conferences, 31 noted the need to improve in this area.

- No template or guidance for encouraging and standardising GP submissions to case conferences. Some had developed standardised templates but they were not always used, or were not effective in prompting the correct information.<sup>i</sup>
- Barriers that prevented GPs attending case conferences in person. These included conferences being organised during surgery hours, in inconvenient locations and at late notice. In the large majority of cases no alternative arrangements had been made to facilitate GP participation.<sup>j</sup>
- Not being kept informed by other agencies. In many areas, information sharing by other health staff with GPs was absent or ineffective.<sup>k</sup>
- Capacity problems, including recruitment difficulties and limited resources, which affected the consistency and quality of GP contributions. This included vacant named GP posts in several areas. Where named GPs were appointed, they were often positively supporting safeguarding practice in primary care.

i. Reports in 12 areas noted a lack of guidance or templates and nine had templates that were being used inconsistently.

j. Reports in 17 areas showed the barriers that prevent GPs attending case conferences. These included holding them during surgery time (5), in inconvenient locations (2), at late notice (4), and having a lack of alternative arrangements in 13 reports.

k. Inspectors noted a lack of, or ineffective, information-sharing by other health staff with GPs in 20 reports.

### LACK OF GP ENGAGEMENT IN CHILD PROTECTION

In one area GPs were not routinely responding to requests from school nurses and other professionals for information relating to the health of children subject to child protection plans. There was no evidence of GP attendance at case conferences in the child protection cases reviewed. The GP reports that were reviewed contained very basic information and little that would inform the parenting capacity of the adult or the child-parent interaction that was observed.

### Improving quality through partnership working and shared frameworks

One barrier to sharing confidential information about children, their families and carers, was a lack of trust about how other agencies would interpret and use information. The review found that where relationships were strong between primary care and other services (including the CCG and the designated doctor), information was shared more appropriately and child protection engagement and contributions followed better practice.

Face-to-face meetings, such as multi-disciplinary team meetings and safeguarding forums also improved the quality of shared information. GPs' strongest partnerships were with health visitors, with whom they often had regular contact. Information-sharing arrangements were much more variable between GPs and school nurses, midwives and CAMHS, where there had been fewer opportunities to work closely together.

### SUCCESSFULLY DEVELOPING THE DEVON ASSESSMENT FRAMEWORK

In Devon, an **alternative early help model** had been developed to provide a more integrated system for identifying any type of need for children and young people aged 0 to 25 years. This was developed as a comprehensive system that included support across education, health and social care.

The model was viewed positively across the system. Children's inspectors saw some examples where it had been effective in supporting families and reducing children's vulnerability.

The consistency of information sharing was also improved through the use of standardised templates or frameworks, such as the Common Assessment Framework (CAF). The CAF was designed to help coordinate the assessment of a child who could benefit from early support.<sup>21</sup> Where the CAF was used, staff considered a more holistic view of the needs of the child when assessing and planning their care.

However, where the CAF identified children who required support through early help, there was significant variation in the recording and communicating of information compared with those under more formalised child protection plans.

## RECOMMENDATIONS

Although improvements have been made in how health staff identify safeguarding concerns, a number of issues have been identified that have a detrimental impact on the quality of information-sharing, which must not stand in the way of the need to promote the welfare and protect the safety of children. These should be addressed as a priority across health systems.

In practice this means:

- Providers ensure that healthcare staff are trained in how to articulate the risks identified to a child and made aware of local policies. This should be delivered at a multi-professional level to improve understanding of how each agency uses information.
- Healthcare staff across agencies strengthen relationships through joint training and regular contact in order to nurture trust and work together more effectively.
- Providers develop clear guidance and templates to standardise the information that is shared where appropriate, such as case conference reports, and embedded into practice. Referrals and reports are regularly audited for quality assurance.
- GPs are supported to better contribute to child protection meetings and case conferences. This may include improved flexibility in arrangements such as time, format, location, notice given and use of technology.
- GPs contribute to case conferences, even when they are unable to attend, for example by providing a comprehensive report that is discussed with the social worker or conference chair ahead of the conference date.

## 4

## The five 'P's that support multi-agency working

In addition to assessing risk and communicating it, keeping children safe requires collaborative working across the health sector, as well as with educational, social care and justice organisations.

The review identified the systems that exist to facilitate effective multi-agency working at several levels:

- **Physical systems** (IT or paper-based) – support accurate and timely documentation and information sharing.
- **People** – facilitate joined-up working and strengthen partnerships. It is often individuals who work hard to ensure that any gaps in existing systems are anticipated and avoided.
- **Policies, protocols and pathways** – help staff to be clear on what should be done when, where and by whom, and reduce variation in practice.

Children experienced more coordinated, joined-up and efficient care where there were arrangements for how to share information, make referrals and provide support. This was the case for child safeguarding arrangements as well as for looked after children's services.

### Physical systems

Being aware of previous concerns or potential vulnerabilities is vital to ensuring that a child's risk is fully assessed, particularly for services without a continuity of care to the child, such as A&E departments, minor injury units, walk-in centres, GP out-of-hours services and sexual health units. A number of areas had integrated and compatible electronic systems that used alerts to flag vulnerable and looked after children.

In A&E departments, examples of well-designed electronic systems were seen that prompted practitioners to ask certain questions and record particular information, ensuring that vital information is not missed.

### EFFECTIVE FLAGGING SYSTEMS IN A&E DEPARTMENTS

Several effective flagging systems across trusts in Kent reflected good practice. For example, electronic flagging systems in A&E identified those who were subject to a child protection plan. In Darent Valley Hospital, young people with 10 or more attendances were automatically reviewed by the consultant paediatrician responsible for safeguarding.

Flagging systems were also helping to identify vulnerable, safeguarded or looked after children in GP records, maternity units and CASH services. Missing children and those identified as being at risk of domestic violence were also flagged at multi-agency risk assessment conference (MARAC) meetings.

In primary care, single patient information systems across many health disciplines were used as an effective information sharing tool. They offered a way of capturing essential safeguarding information, and could be used to 'task' other professionals to follow up with the child, which was helping to prevent missed actions.

Where integrated systems were not in place, there was an over-reliance on staff to remember to explore and record all the key information related to assessing a child, including relying on children or families to declare their child protection or looked after status. There was also a reliance on individual members of staff to remember those at risk and contact other agencies to corroborate information.

### THE CHILD PROTECTION INFORMATION SHARING (CP-IS) PROJECT

**CP-IS** is a national project designed to improve the level of protection given to children who present in unscheduled NHS healthcare settings. Building on existing infrastructure, it allows healthcare staff to identify if a child is subject to a child protection plan or is looked after. This supports them in their decision-making and encourages communication with social care.

Access to CP-IS information is controlled by NHS smartcard security. Local authorities feed information from their social care systems into a secure central data store area in the NHS national Spine. While health staff are registering a child at their care setting they are then informed of the child's child protection status.

A record of who has viewed the indicator flag is available to social care and healthcare staff, allowing them to see if a child has visited a range of different unscheduled care settings. This is important, as serious case reviews have demonstrated that abusive and neglectful behaviour can be masked by moving between different services.

As of April 2016, 24 local authorities had implemented CP-IS, equating to 28,054 or 23% of child protection records being uploaded to the Spine.<sup>22</sup> There is a NHS Standard Contract requirement that NHS organisations implement CP-IS by 31 March 2018. The national implementation of CP-IS is endorsed by CQC.

### INCOMPATIBILITIES IN MATERNITY

In one area, five hospitals were using one IT software system for their electronic patient records in the maternity departments, but the sixth had implemented a different system. This raised concerns about the consistency of information exchange between maternity providers across the city, particularly because women had the choice to deliver in any one of the city's hospitals. The community midwives therefore had access to different levels of data for the different women they cared for. This created additional work for staff, introduced the risk of error and the possibility that the needs of newborn and unborn children could be missed.

### INEFFECTIVE FLAGGING SYSTEMS IN A CASH SERVICE

The electronic management system in use in one sexual health service did not automatically flag young people under the age of 13 or those who were looked after. The arrangement required professionals to use special notes to ensure their vulnerability was captured, and these had to be separately checked to inform any re-presentation. The local professionals recognised that this was not providing the levels of assurance required and it was highlighted as an organisational risk.

## People

The people who were responsible for ensuring that children's care was joined-up, with robust information sharing arrangements, were essential to a system that was keeping children safe.

For example, in primary care the services worked more effectively to identify and act on risks to children where there were identified people who were responsible for overseeing safeguarding, including named GPs. Unfortunately these posts were not always filled and individuals taking on

these roles frequently did not have the capacity to fulfil all of their responsibilities.

Effective safeguarding was often seen in A&E departments that had a paediatric liaison practitioner. Where this role was effective, the practitioner acted as a coordinator for children's health and safeguarding. For example, they:

- Coordinated weekly paediatric A&E meetings and child safeguarding training.
- Anticipated gaps in provision and ensured that alternative arrangements were made.
- Developed new pathways of care (such as an under-16 self-harm pathway, and a paediatric summary form).
- Strengthened relationships with other services, such as CAMHS.
- Regularly attended multi-agency meetings.
- Took responsibility for the quality assurance of decision-making and referrals.

## Policies, protocols and pathways

Concerns about children are less likely to be missed where there are jointly agreed ways of working that everyone understands and knows how to access. One example is a policy for when children do not attend (DNA) an appointment. It is important to highlight that the children themselves do not actually 'DNA' appointments; rather, it is that they are not brought to appointments by their family or carer, which could be a flag for further safeguarding concerns. This has led to the proposal that DNAs are reframed as 'was not brought' (WNB) events, which should trigger the question "why were they not brought?"<sup>23</sup>



### COMMON FEATURES IDENTIFIED BY CLAS REVIEWS OF A SAFE PAEDIATRIC A&E DEPARTMENT

- **Compatible IT systems that reliably flag vulnerable children, those who are looked after or considered to be at risk.**
- **A paediatric liaison practitioner in post to take the lead on ensuring coordinated care for children's health and welfare.**
- **Review systems in place to assure decision-making on action and referrals.**
- **All areas of the paediatric A&E waiting room visible by staff (important both for monitoring a child's clinical condition, but also for observing interactions between children and the person(s) accompanying them).**
- **Sufficient qualified and experienced paediatric staff in post, and all staff up to date with safeguarding training.**
- **An established self-harm pathway with access to CAMHS assessment and inpatient treatment where necessary.**
- **Close working with adult A&E staff, particularly on training and sharing information about parents who present with behaviours of concern.**

The review found that without a DNA/WNB policy, practitioners lacked guidance to ensure consistent practice in minimising risks to children.<sup>1</sup> Early signs of disengagement from a service could be a cause for concern, so it is crucial that all services have a jointly agreed process for when a child is not brought to an appointment, to ensure that concerns are appropriately followed up.<sup>20</sup>

Where DNA/WNB policies worked particularly well:

- A triage-process ensured that the level of risk to any one child was reviewed before proportionate action was decided.
- Staff pursued individual cases with determination and care to ensure that the child or their carer was aware of the appointment and process.
- They were jointly agreed and spanned across more than one service, or at trust level, and they were well understood by staff across all agencies.
- A multi-agency response was in place where appropriate.

### ROBUST DNA/WNB POLICIES

**West Sussex:** Surrey & Sussex Healthcare Trust had a robust DNA protocol in place. Where a child failed to attend an appointment two or more times (or recurrent rescheduling of appointments) the case was automatically discussed at the weekly safeguarding meeting. If a child left A&E before being seen, notification for follow-up was sent to community health and primary care services to ensure that their needs were met.

**Torbay:** In the cases we reviewed, all health services (including GPs and adult services) demonstrated robust responses in line with the local shared DNA policy for children who did not attend who were identified as being vulnerable or subject to child protection plans. The safeguarding children's team was copied into DNA letters for children who were subject to child protection plans. This information was then forwarded to the relevant community health practitioner for follow-up.

1. We made recommendations in 7 of 50 reports to improve implementation or adherence to at least one DNA/WNB policy.

### OUTSTANDING CHILD SAFEGUARDING PRACTICE IN PRIMARY CARE

Huntingdon Road Surgery in Cambridge was recently rated outstanding by CQC for the 'safe' key question, in part due to the safeguarding work being carried out.

The practice's safeguarding lead was active in ensuring that children were kept safe. A comprehensive library of safeguarding information had been developed that was available to all staff on the practice's intranet, including local safeguarding newsletters, case conference reports, guidance on female genital mutilation, and safeguarding templates. Safeguarding policies and protocols were detailed and appropriately tailored to the practice.

There was a robust system of recording keeping, including responding to requests for safeguarding information and ensuring that all staff were up to date with safeguarding training. The practice had recently hosted a training event that included discussing lessons learned from serious case reviews in the area and presentations from representatives of the multi-agency safeguarding hub, Cambridgeshire Sexualised Behaviour Service and Cambridge constabulary.

The practice had carried out a detailed audit of the quality of coding of safeguarded children in case notes, which identified areas for improvement. There had also been active follow-up of children on child protection plans who had not attended immunisation appointments.

*Note: This example did not form part of the CLAS reviews but has been included as an example of robust safeguarding practice in primary care.*

Following up missed appointments can ensure that children and families in early need of help are identified and that appropriate support is given. This is also important in midwifery services, where working together with health and social care services to support women and families can make a difference.

The table below collates the good practice that was seen across several areas where this was working well, and illustrates how effective multi-agency working can be supported by policies, protocols and pathways.

The review identified a worrying gap in child safeguarding policies, protocols and pathways in minor injury unit (MIU) departments. Many MIU departments were unable to demonstrate that child safeguarding issues had been fully considered. This raises major concerns for the welfare of children accessing emergency care through these services.<sup>m</sup> The table below summarises the features of concern.

m. We visited a minor injury unit in 25 reviews, and made recommendations in 10 of those reports to review and improve the safeguarding arrangements.

### Multi-agency working to provide early help: What 'good' looks like

**Pre-birth protocols** Midwives use pre-birth assessment templates to identify and follow up concerns about the health and wellbeing of mothers or the safety of their unborn babies, including appropriate use of a common assessment framework (CAF).

- Systems alert staff to existing knowledge about vulnerable cases.
- Clear policies are used to escalate a safeguarding concern.
- Non-attendance at appointments is routinely followed up.
- Antenatal home visits are considered where appropriate.

### Pathways

- Clear pathways for specialist support are available for women and their partners who:
  - have learning disabilities
  - have mental health problems
  - have drug or alcohol misuse problems
  - have experienced domestic violence
  - are teenagers (e.g. family nurse partnership)
- Joint clinics are available in some areas, and specialist midwives support colleagues with complex cases and in both internal and multi-agency liaison.

### Partnerships

- Teams work together as part of early help multi-agency meetings attended by health (including CAMHS), police and social care.
- Community midwives meet regularly with health visitors and GPs to discuss and jointly visit vulnerable mothers-to-be in their area.
- There is effective liaison between maternity and A&E departments, adult substance misuse and mental health services.
- Maternity services routinely receive all police reports involving women who are pregnant or have recently given birth.
- Midwives and health visitors prioritise attendance at child protection meetings.
- A common pathway exists to ensure that there is a consistent response with all appropriate agencies involved.

(These examples were collated from good practice seen across several areas including Solihull, Stockton-on-Tees, Swindon, Wiltshire and South Gloucestershire)

Causes for concern in MIU departments	
<b>Protocols, policies and pathways</b>	<ul style="list-style-type: none"> <li>• Limited links with other MIU or A&amp;E departments, with staff reliant on voluntary disclosure about other recent attendances.</li> <li>• No policy for logging child attendances or formal process to follow up those who attend.</li> <li>• No safeguarding alert or flagging system on the electronic system in use and no facility for staff to flag records manually.</li> <li>• Limited access to risk assessment tools, e.g. for child sexual exploitation (CSE).</li> <li>• No self-harm pathway for young people.</li> </ul>
<b>Documentation</b>	<ul style="list-style-type: none"> <li>• Notes illegibly written.</li> <li>• No details of the accompanying adult or person with parental responsibility.</li> <li>• No written account of the history according to the child.</li> <li>• No safeguarding prompts on admission templates.</li> <li>• Discharge paperwork not completed.</li> <li>• Poor quality onward referrals with lack of articulation of the risks to the child.</li> </ul>
<b>Staffing, training and supervision</b>	<ul style="list-style-type: none"> <li>• No paediatric-trained staff in the department.</li> <li>• Frontline MIU staff not trained to appropriate levels of safeguarding competence.</li> <li>• Extensive use of locum doctors and bank or agency nurses without appropriate governance and supervision to ensure safe practice.</li> <li>• No formal safeguarding supervision in place, such as access to a safeguarding lead with advice and guidance available on an (at most) ad-hoc basis.</li> </ul>
<b>Quality assurance</b>	<ul style="list-style-type: none"> <li>• Notes not routinely audited to assess quality of record-keeping, including of safeguarding issues.</li> <li>• Lack of oversight and clinical governance of safeguarding.</li> </ul>

## RECOMMENDATIONS

Effective multi-agency working that involves seamless information sharing must be supported by compatible electronic systems, people in post to ensure that the whole complex system is working well together, and agreed ways of working in the form of policies, protocols and pathways. Health services should have all these elements in place to ensure coordinated care for children.

In practice this means:

- All areas have compatible electronic systems that are able to reliably flag concerns and share information about vulnerable children and families across sites and agencies. In unscheduled care services, this should include implementing the **Child Protection – Information Sharing (CP-IS) project**.
- All services have processes in place to coordinate the follow-up of concerns about children, particularly in unscheduled care settings. A named individual(s) should ensure that these processes are regularly audited and reviewed.
- All agencies have jointly agreed protocols for dealing with the situation where a child is not brought to an appointment.
- Providers of minor injury units review the effectiveness of their child safeguarding arrangements and ensure that they meet appropriate standards.

## 5

## Finding the hidden child

The National Society for the Prevention of Cruelty to Children (NSPCC) estimates that for every child identified as needing protection from abuse, another eight are suffering abuse in silence.<sup>2</sup>

However, there is insufficient drive in our health and social care system to find out the prevalence of safeguarding issues to look for these missing thousands. The focus is predominantly on what practitioners are doing for those children who have already been identified as being at risk.

Finding the ‘hidden child’ is about taking a holistic approach when children are assessed and cared for in addition to maintaining a professional curiosity about their situation and the people around them. It is also about how effectively staff listen to and involve children. Young people who have recently left care told us that trust in the professional is crucial and that they won’t open up about issues unless they feel that the person actually cares. They implored staff in health services to take the time to get to know them, and to be curious about the things that don’t add up. This is vital to identifying children in early need of help, as well as those who have been suffering for years.

**“Sometimes it feels that people are just doing a job – I won’t share if I don’t think you care.”**

A recent care leaver, The Who Cares? Trust

The CLAS reviews have shone a light on areas where children are most often overlooked, including adult health services – particularly mental health and substance misuse – through a ‘Think Family’ approach, as well as the structures in place to identify some of the most concealed and dangerous risks to children: child sexual exploitation and female genital mutilation. These agendas for child health and safeguarding have had a renewed focus but how well embedded they are varies significantly across the country.

### Think Family

Joined-up working between adult and children’s services to meet the needs of families is a major challenge. Adult care and children’s care have different legal frameworks, policies and practices. Information-sharing between the two has traditionally been poor. As a result, the ‘hidden child’ is not always considered when an adult is seen in a service with, for example, mental health problems, domestic violence, or substance misuse concerns.

'Think Family' is a national agenda, first introduced by the Cabinet Office's Social Exclusion Taskforce in 2007.<sup>24</sup> The Think Family approach in adult health services is about understanding the effect of the family situation on the child, identifying early risk to children and ensuring that the support provided by all services is coordinated and focused on problems affecting the whole family.<sup>25</sup> The framework to support the child and family is provided in the 2015 guidance, *Working Together to Safeguard Children*.<sup>1</sup>

The Think Family approach has been widely accepted as good practice, yet the review found significant variation in the extent to which it is understood and embedded in the work of frontline health staff. For example, Think Family practice was not well embedded in the majority of adult mental health services.<sup>n</sup> Staff did not consistently consider the impact of parental mental ill-health on children. Even where questions about children were included in recording systems, the clarity, consistency and detail of these varied.

### THINKING FAMILY WITH HIGH-RISK MEDICINES

In the adult substance misuse service in Birmingham, there were robust arrangements to ensure that any risks to children were identified as part of the assessment process. Where children were in the household, information was provided about the safe handling and storage of medication, such as methadone, to ensure their safety.

There was a process of on-going risk management, which enabled early follow-up of any additional support or safeguarding concerns for children.

Where Think Family was well-integrated in adult mental health services:

- Detailed risk assessment tools were in place for adults in contact with children.
- Adult mental health teams carried out home visits for a complete assessment of the home environment, including children staying or living there.
- Information-sharing protocols were in place to ensure that attendance at child protection case conferences was prioritised, contributions submitted and social services informed if adults miss appointments and the child is identified to be at risk.
- Care plans and relapse indicators routinely recorded the needs of the child and parenting goals were consistently actioned in recovery plans.
- Children's health professionals were invited to attend adult mental health inpatient discharge planning meetings.
- Active engagement work promoted awareness of, and developed, systems to support the Think Family approach.

The Think Family approach was better integrated in adult substance misuse services than in mental health, as CQC has found in previous work with Ofsted.<sup>26</sup> Good practice was supported by reliable recording and reporting systems, close managerial oversight, robust quality assurance and involvement in joint training.

n. Of the 34 reports that mentioned Think Family practice in adult mental health services, 25 noted that practices were not embedded (although a number of those areas were working towards this approach) and nine commented that the approach was well integrated.

**Think Family in adult substance misuse services: What 'good' looks like**

<b>Identifying risk</b>	<ul style="list-style-type: none"> <li>• Risk assessments and screening tools ensured a joint focus on the needs of any children present in the family, including unborn children, and they were revisited regularly when circumstances changed.</li> </ul>
<b>Forward planning</b>	<ul style="list-style-type: none"> <li>• Contingency plans for children were made as part of recovery plans, in the event that a parent deteriorated or failed to engage.</li> </ul>
<b>Joint working</b>	<ul style="list-style-type: none"> <li>• Reliable liaison with health visitors and school nurses helped children whose parents were service users to access support services.</li> <li>• Effective joint working with local midwifery services, adult mental health services and lead child health professionals.</li> <li>• Joint visits undertaken where appropriate.</li> <li>• Consistent use of a multi-agency template when making referrals, which were prompt and the risks to the child well-articulated.</li> <li>• Additional support for families available, for example, through a specialist family support team.</li> </ul>
<b>Information sharing</b>	<ul style="list-style-type: none"> <li>• Robust information-sharing arrangements were in place across the system, including for example, about the safe handling and storage of high-risk medication where children were in the household.</li> </ul>

**RECOMMENDATIONS**

Think Family practice, where fully integrated into a service, supports the holistic assessment of children and their families, and helps to identify children at risk. Significant improvement is required in adult services to embed a culture where the needs of children are routinely considered and addressed.

In practice this means:

- Significant improvement is made in embedding Think Family in all adult health services, particularly in adult mental health services, to consistently consider the needs of any children in contact with a service user, who might be at risk of harm.
- Improved recording of all relevant information about children and families, integrated IT systems that facilitate the sharing of information, and closer joint working, information sharing and training between adult and children's services.
- A family perspective is developed at all levels of health, including policy and performance indicators, in order to make progress in the Think Family approach.
- CQC ensures that Think Family is embedded in our inspection approach across all adult health services, including mental health services.

## WORKING TOGETHER TO IDENTIFY RISK

In Stockport's adult drug and alcohol service, thorough risk assessments were undertaken about parental/carer responsibilities and contact with children. Home visits were offered routinely for service users with children under five years old. The team liaised with health visitors and schools to help children of service users to access support.

The area had developed a 'central youth' hub for a number of services, including a substance misuse service, specialist teenage pregnancy midwife and family nurse partnership. The services shared information where risks were identified and worked cooperatively with other services, including the looked after child health team, multi-agency sexual exploitation group and children's social care, to ensure young people's safety.

## Child sexual exploitation

Child sexual exploitation (CSE) involves taking advantage of a situation, context or relationship (invariably involving an abuse of power) in order to coerce a child to accept something (such as food, gifts, money, affection, protection) in exchange for sexual acts or activity.<sup>27</sup>

The review found the majority of local authority areas had gaps or concerns in the arrangements to identify and protect children from CSE.<sup>o</sup> In local authority areas where the identification of CSE was ineffective, there was poor awareness of the risks, coupled with an inadequate joint approach to information sharing and risk management. There was also a lack of multi-agency working or protocols, particularly in emergency departments, and limited links to existing child protection processes.

**“You have to find out what’s going on behind the scenes to keep us safe. I was scared into not telling anyone the bad things my foster carer was doing because she threatened me, but there were signs.”**

**A recent care leaver, The Who Cares? Trust**

This very challenging area requires a strong partnership approach across health, social care, and the police and justice system, supported by formalised decision-making arrangements, protocols for information-sharing and engagement across services. Where this worked well, arrangements took many different forms across the country, including multi-agency groups or risk panels, CSE best practice forums and other formalised multi-professional pathways. However, most areas were still in the early stages of their response to CSE.

Contraception and sexual health (CASH) services have a significant role to play in CSE. The review found most services had screening and risk assessments in place, but many needed to improve in order to be effective.<sup>p</sup> Where there was a robust approach, it was supported by the use of risk assessment proformas, such as 'Spotting the Signs of CSE'.<sup>28</sup> When used effectively, the assessment was repeated each time a young person presented, allowing practitioners to fully assess potential vulnerabilities at each and every contact. It additionally provided the opportunity for an in-depth discussion with the young person about their circumstances, as well as their emotional health and wellbeing.

o. 36 of the 49 reports that mentioned CSE described at least one gap or concern in the arrangements in place to identify and protect children and young people from CSE.

p. 22 reports mentioned strength of screening and risk assessments, of which 13 had robust arrangements and 9 needed improvements.



Other services used creative approaches to engage with those most at risk of CSE, supported by a range of targeted education campaigns such as:

- outreach services aimed at children and young people most at risk of CSE
- promotional materials placed in identified ‘hotspots’ of risk
- courses on CSE targeted at young people
- use of creative materials to explain risks to young people, such as a short film called ‘My Dangerous Lover Boy’, and an educational resource called ‘Love or Lies’.<sup>29</sup>

Across all services, the review highlighted a significant lack of awareness of CSE among staff, including limited knowledge of national guidance on assessing consent and confidentiality in those under 18 years old and the legal obligations concerned with children younger than 13 years. Practitioners themselves told inspectors they did not feel fully skilled and equipped to recognise the indicators that may suggest a child is at risk from CSE.

### EXEMPLARY WORK ON CHILD SEXUAL EXPLOITATION

Swindon’s local safeguarding children board (LSCB) had developed a protocol for managing risk across agencies, which included outlining the roles and responsibilities for those working with children deemed to be at high risk of CSE.

The multi-agency risk panel was well attended by children’s social care and sexual health services, police, the youth offending team, locality teams, and CAMHS. It linked well with the LSCB sexual exploitation and runaways sub-group.

The panel introduced a **vulnerability checklist** to support risk assessment and discuss cases deemed to be high risk. Where young people were approaching 18 years old, transition plans were considered, as were pathways into adult safeguarding or other appropriate risk management forums to ensure on-going protection.

The inspection noted good work across services:

- Sexual health – Swindon Integrated Sexual Health was making a significant contribution in identifying young people at risk of CSE while delivering a supportive and high-quality contraception and sexual health service, which young people wanted to engage with.
- School nurses – working jointly with school safeguarding leads, school nurses had developed a four-week targeted course for young women identified as being at risk of CSE.
- CAMHS – a practitioner from the outreach service for children and adolescents team was effectively supporting those considered to be at high risk from CSE.

The panel’s work was further supported by the Swindon multi-agency information sharing protocol, which ensured that no single agency was holding on to information about risks to children.

### Female genital mutilation

Female genital mutilation (FGM) is the term used to describe any procedures that involve partial or total removal of the external female genitalia for non-medical reasons.<sup>30</sup> It is prevalent in specific ethnic populations in Africa and parts of the Middle East and Asia.

FGM is illegal in England and Wales under the FGM Act 2003.<sup>31</sup> Health and social care professionals and teachers now have a duty to report known cases of FGM to the police if the girl is younger than 18 years old.<sup>32</sup> Amendments to the FGM Act 2003 in 2015, together with increasing national awareness, has meant that the inspection’s focus on FGM in more recent CLAS reviews has increased compared with those reviewed in 2013.

Some individual practitioners have developed a high level of understanding of the risks and associated cultural issues, and are raising awareness of the issues on local and national levels. Although some local authorities have an improved awareness of the women who have undergone FGM and the risks to young girls, most were not challenging it effectively.

The review found effective, well-embedded work on FGM in only a small minority of areas.<sup>q</sup> Where there was partial or no work on FGM, this was often underpinned by a lack of awareness among practitioners and resulted in insufficient risk assessments. Good practice was also let down by an absence of comprehensive policies, training and joined-up working.

### RESPONDING TO CULTURE-SPECIFIC RISKS

Brent has a cultural and ethnic population that suggests large numbers of women are at risk of FGM. Maternity services were offering two clinics at both main hospitals for reversals, as well as clinics for counselling and follow-up support. The Head of Midwifery was passionate about the issue, contributing to local and national discussion on how best health services can prevent FGM and support women and children. Plans were in place to work with the local population and other key stakeholders, recognising the sensitivities around this practice and the need to engage communities.

### DEDICATED MIDWIFERY SERVICES

Specialist midwifery services for women who have undergone FGM were in place across providers in Birmingham. Innovative practice and consultation with local communities was seen, including work with a local Somalian Women's Group, on how best to support women when disclosing FGM. For example, pictorial bookmarks had been developed to help women explain to practitioners the extent of their injury. '**Birmingham Against FGM**' had become a part of the local safeguarding children board sub-group, focusing on education of GPs and raising community awareness of FGM.

Where FGM was disclosed to midwives, a 'cause for concern' form was generated and shared with the woman's GP and health visitor. However, there was limited consideration of information sharing with school nursing if the woman had other female children of school age.

### UNACCOMPANIED ASYLUM SEEKING CHILDREN

More recent CLAS reports have focused on how health services are meeting the needs of unaccompanied asylum seeking children (UASC). In one area, the review found that medical staff undertaking assessments of UASC did not have specific training or support in working with this minority group. The initial health assessments seen did not demonstrate awareness of issues relevant to their asylum seeking status that may impact on physical or emotional wellbeing. These issues were undermining effective care planning.

q. Of the 28 reports that commented on FGM work, just 5 noted that it was well-embedded in practice.

## RECOMMENDATIONS

The hidden harms to children from child sexual exploitation and female genital mutilation make keeping children safe a particularly challenging task. A robust approach from the health sector, working closely with social care and the police, is vital to identifying and protecting children at risk of these, and other, hidden harms.

In practice this means:

- All healthcare staff are enabled to take the time to build trusting relationships with the children and young people they work with, in order to create the environment for them to find out about issues that could be hidden from view.
- Health services appoint a lead person for both CSE and FGM who is responsible for ensuring that cases of CSE and FGM are appropriately handled, monitored and recorded.
- Standardised, multi-agency training programmes and supervision are available to all staff working in health. This should include how to identify risks and signs of CSE and FGM, how to ask the relevant questions of children, and how to escalate concerns. It must include UK law on reporting FGM.
- There are multi-agency policies and pathways and information-sharing arrangements in place to protect those who are at risk of CSE or FGM, or have undergone FGM.
- Services seek to understand and meet the physical, mental and emotional health needs of those who have been victims of CSE and women and girls who have undergone FGM.
- Commissioners and local safeguarding children boards identify the risks in their local communities, working with the voluntary sector organisations and those who have experienced CSE and FGM, so that their response meets the needs of their communities.

## 6

## Transitions and access

**Children's transitions to adult services in health**

When young people with health needs leave paediatric care to join an adult service, their experience of that transition can be very variable. As CQC found in the 2014 report on children's transitions to adult health services, *From the*

*pond to the sea*, young people and families are often confused and at times distressed by the lack of information and support about which services are available to meet their complex health needs.<sup>33</sup> The absence of an established pathway or dedicated changeover process leads to a poorly organised and frustrating transition for young people.

**KEY FINDINGS: FROM THE POND TO THE SEA: CHILDREN'S TRANSITION TO ADULT HEALTH SERVICES**

The report recommended that services follow existing good practice guidance to ensure that young people are properly supported through transition. From the age of 14, every young person with complex physical health needs should have:

- A key accountable individual responsible for supporting their move to adult health services.
- A documented transition plan that includes their health needs.
- A communication or 'health passport' to ensure relevant professionals have access to essential information about them.
- Health services provided in an appropriate environment that takes account of their needs without gaps in provision between children's and adult services.
- Training and advice to prepare them and their parents for the transition to adult care, including consent and advocacy.
- Respite and short break facilities to meet their needs and those of their families.

The report also recommended that commissioners should listen to and learn from the experiences of young people and their families, GPs should be involved at an earlier stage in transition planning and that adolescence/young adulthood should be recognised across the health service as an important developmental phase.

The need for a supportive transition applies to all health services, but this review has built on the findings from CQC's transitions report to share what was working well in mental health and substance misuse services. The CLAS reviews identified some good practice:

- Services had a dedicated transition worker to coordinate a smooth transition for young people from children's to adults services.
- Good partnership working was evident, for example, between CAMHS and young people's substance misuse workers, with adult mental health and substance misuse workers, and with looked after children's nurses.
- Regular professional meetings discussed young people aged 17 who were likely to need ongoing services from the adult team. These informed joint 'transition clinics' run with the young person, the children's service and the adult's service during the period of transition (often six months).
- Panels or teams were in place to review young people in transition and arrange support for those who may not meet the criteria for adult mental health services.
- To inform future improvement, services asked for feedback from young people on their experience of transitioning to adult services.

### CLEAR TRANSITION PATHWAY

There was a robust transition policy and pathway for young people moving from the CAMHS to the adult mental health teams in Wakefield. The transition process started when the young person was 17½ years old, continuing for up to six months. During the transition period, the services worked jointly and involved the young person. Appointments were usually held in familiar CAMHS settings. These arrangements enabled stability and ensured that young people were not lost in the system during this critical time.

However, children's experiences of transition in health services can still be very poor, with significant variation seen in the transition pathways in place particularly from CAMHS to

adult mental health services. More needs to be done to meet the recommendations made in *From the pond to the sea*.

### Continuity of care for looked after children when moving area

Many children in care are moved several times a year, often outside their home local authority area.<sup>r</sup> In 2013, more than one in 10 looked after children lived more than 20 miles from their home community.<sup>34</sup> The review identified a number of concerns about care provision in transition for these looked after children and young people.

**“When we've been moved out of borough, the care we're getting suddenly gets cut off then we have to start again when we go somewhere new, usually at the end of the waiting list. Why shouldn't we be prioritised to restart our care in the new area?”**

**A recent care leaver, The Who Cares? Trust**

A child placed out of area is frequently unable to access health services, such as regular health assessments or CAMHS, as neither the home or out-of-area local authority will accept responsibility for the commissioning or funding of the service. This leaves vulnerable young people without access to the care they need for long periods.

Where health reviews were carried out regularly, the looked after children's nurse often retained responsibility and continued to travel to see the child. Continuity of care also worked well where provision had been made at a commissioning level, for example, providing specific out-of-area services.

r. For the year ended 31 March 2014, 35% of young people leaving care aged 16 or above had five or more different placements in the care system, **NAO (2015)**.

### CONCERNS ABOUT ACCESS FOR LOOKED AFTER CHILDREN

Looked after children health teams in one area were experiencing difficulties in ensuring that children placed out of area were able to access health services, including health assessments. Work with social care was on-going to ensure that services were in place before placements were made. There were also recognised problems in children accessing CAMHS if placed out of area. This meant that some children were disadvantaged by being placed out of their home county.

Young people told inspectors they frequently had to join the end of a waiting list when they moved out of an area or returned to their home area. Many felt they should be prioritised to access services, given their inequity of service when moved and more complex needs. This is supported by both NICE guidance and the Education Select Committee's 2016 report.<sup>35, 36</sup>

CQC agrees that no looked after child should face unfair delays in accessing the health services they need, particularly when they are moved to another area. This should be reflected in statutory guidance and addressed by close liaison between different local authorities and CCGs.

### Transition to independence for care leavers

The period of transition in establishing independence is especially difficult for young people in care. Despite this, the review found that support for care leavers was unacceptably poor, with health services failing to cater for their needs or help to prepare them for the next stage in their life. Only a minority of areas were providing good health support for care leavers.<sup>5</sup>

Care leavers told inspectors that when agencies fail to ensure that their health information stays with them on their journey through health and

social care, there is a significant and detrimental impact on them as young adults. Most young people did not have adequate health support as they left the care system; they were not routinely given their health history or age-appropriate health information packs, and told us they did not feel involved in their leaving care plan.

**“A lot of kids in care, we don't know our history, we don't know if there's family health problems. It would be good to give us a chance to have an MOT at 18 so we know where we are. We've got no one to ask about inherited things. We don't know anything.”**

**A care leaver**

The review identified effective approaches to encourage young people to have better ownership of their health history and plans, such as through the use of 'health passports'<sup>t, 37</sup>. However, only a very small minority of CLAS reports noted that these were being given to care leavers consistently.<sup>u</sup>

### GOOD USE OF HEALTH PASSPORTS

Young people leaving care in Middlesbrough were offered a comprehensive health summary by way of a 'passport', developed in consultation with young people in care. The passport was tailored to each individual. All young people leaving care were advised of their family health histories (where known), immunisation status, how to register with a GP and dentist and who to contact if they needed any more information. Any information was also provided in a format that best suited their individual needs.

t. NHS England has produced a **passport template** developed by young users, which they can use to detail their own story.

u. Five of 50 reports noted the comprehensive use of health passports or summaries for care leavers that were consistently in place and working well.

s. In the 24 reports that specifically commented on health support for care leavers, six noted this being good or well-developed, and 18 noted it being underdeveloped.

Another concern for looked after children was the lack of support they received after leaving care. Young people in care have to leave by their 18th birthday and some have to live independently as soon as they leave care. A third of young people aged 16 or over who left care in 2013/14 did so before their 18th birthday.<sup>38</sup>

**“I don’t know why the system thinks a 16 year old is an adult. Kids in care haven’t even had a childhood. How can we be an adult at 16?”**

**A care leaver, The Who Cares? Trust**

In 2013, the government published the Care Leaver Strategy, setting out how it planned to improve support for care leavers.<sup>39</sup> However, the review found support options for these vulnerable young people were frequently inadequate and reliant on inflexible age boundaries, particularly for those who fell outside the threshold for adult mental health services yet had emotional needs that affected their future prospects.

**“I felt let down by the adolescent CAMHS unit. Once I was 18 it was as though I was at the end of the road.”**

**A young woman on an adult mental health ward**

The Education Select Committee 2016 recommended more flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age.<sup>36</sup> This was highlighted as particularly important for CAMHS, which should offer access for care leavers until the age of 25 if necessary. In May 2016, the Government announced its intention to introduce a Children and Social Work Bill to improve the support for children leaving care. It includes the extension of the right to a personal adviser for all care leavers up to the age of 25, who will make sure care leavers receive the support they need.<sup>40</sup>

## EFFECTIVE MENTORING FOR CARE LEAVERS

Older looked after children and care leavers were very well supported by weekly drop-in sessions at a local café in Stockport. They attended regularly and told inspectors that they valued the opportunity to come to a safe environment where they could immediately access health and daily living advice from volunteer mentors in a non-judgemental setting.

Care leavers who were young mums told inspectors they appreciated meeting the designated looked after child nurse every week at the café to get parenting advice and reassurance.

*“Coming here to the café every week is great. I have two babies now and I get such helpful advice about being a mum. I get sexual health advice too as I don’t want to get caught out again”.* A care leaver in Stockport

Since accessing the mentoring service, one care leaver with frequent attendances at A&E for serious self-harm had not attended A&E and had not required intervention from the crisis mental health team.

The review found that in areas where services offered extended support beyond the age of 18, there were often improved outcomes as a result. CQC therefore supports these developments. Young people leaving care should have access to more healthcare provision and support in the vulnerable years before and after their transition to independence.

### COMMON FEATURES IDENTIFIED FROM CLAS REVIEWS OF GOOD SUPPORT FOR CARE LEAVERS:

- **Good support around health for care leavers starts in care, with young people supported to understand how to access the health care they need, such as booking a doctor's appointment.**
- **Final health reviews take place in a timely manner and contain information in previous reviews (including from their GP), birth and early health history, immunisations and family history. This could be given in the form of a 'health passport' or other comprehensive and accessible document.**
- **The young person is involved in making a meaningful shared health plan to prepare for the future and is given all the information they need to ensure they can access the services and support they might need.**
- **There is flexibility to offer the young person additional support and guidance up to age 25, if appropriate.**
- **Specialist support is offered to those who become pregnant upon leaving care or while still in early adulthood.**

### Access to CAMHS for all children

CQC's concerns about access to mental health support extend beyond those for looked after children, to all children. The astonishing statistic that one in 10 children aged five to 16 have a mental health problem, with half being established by the age of 14, was published over 10 years ago.<sup>41, 42</sup> Despite this, minimal up-to-date data is available and many children still experience delays or difficulties accessing CAMHS or local counselling services, leaving them feeling unsupported and unsafe. The review found problems throughout CAMHS from early intervention to the transition to adult services.

**“The waiting list for counselling was so long then I was only offered 10 sessions. You think 10 hours is enough to talk through the 20 years of abuse I've lived through? It shouldn't be time-limited.”**

**A recent care leaver, The Who Cares? Trust**

In the UK, CAMHS has traditionally been organised in a four-tier system, with tier 1 providing general advice and treatment for less severe mental health problems by non-

mental health specialists, leading up to tier 4, which provides highly specialist services for children with serious problems, such as specialist outpatient teams and inpatient units. That said, many areas are moving away from the tier system and to 0-25 services, integrated pathways with single points of contact or new models such as Thrive.<sup>43</sup>

The review found that in several areas, a lack of tier 2 and 3 provision meant that those who did not meet high diagnostic thresholds or looked after children who were not in stable care placements were turned away. This led to long waits, a knock-on effect on other services, such as school counselling to help those in early need of emotional support, and significant additional pressures on tier 4 services as children's needs were not addressed in a timely way.

This led to inpatient beds being frequently unavailable, which meant young people would be given a bed in a different part of the country or placed on an adult mental health ward or medical paediatric ward. In addition, there were gaps in out-of-hours services, a lack of direct access to CAMHS and long waiting lists for specialist services, including for those with a learning disability, attention deficit and hyperactivity disorder and those needing post-traumatic support.



The 2015 *Future in Mind* report set out a vision of improved joint working and paid particular attention to vulnerable groups.<sup>44</sup> This was endorsed by the recent 'Five year forward view for mental health', which called for an end to the chronic underfunding of mental health services.<sup>45</sup> The CLAS review findings highlight the devastating impact this is having on children now, and on their futures.

**“I was put on a long waiting list for CAMHS. I felt like I had to do something stupid [i.e. hurt myself] for them to realise how serious things were.”**

**A recent care leaver, The Who Cares? Trust**

## RECOMMENDATIONS

The period of transition for many young people is already complicated by more acute mental and emotional health needs, so it is unacceptable for access to services to become more difficult. Their experience of transitions in health remains poor. Services need to work together to significantly improve young people's experience of transitions in health, particularly in mental health and substance misuse services as well as for looked after children who are leaving care or moving area. Access to mental health support and treatment for all children must be addressed as a priority, and should include enabling those who work with children in all settings, including education and social care, to provide the right support for children and young people.

In practice this means:

- The recommendations in *From the pond to the sea* are taken forward for all services to improve young people's experience of the transition from paediatric to adult services. In addition, those who do not meet the threshold for adult services, particularly in mental health, are offered alternative support.
- Looked after children who are moved out of area (or are returning to their home area) have robust arrangements in place for continuity of health reviews and are given priority to continue to access the health services they were previously receiving.
- Looked after children's services provide a comprehensive document (such as a health passport), to include a joint plan for their physical and emotional health, access to relevant information, and local options for additional support. Their care history should be summarised and include early and family histories.
- CAMH services receive the necessary funding and support to be able to meet the rapidly rising demands. This must be supported by improved identification and support of mental and emotional health problems for all children at an earlier stage.

## 7

## Leadership

**Good leadership at every level is critical to safeguarding the health and welfare of children. CQC routinely reviews how well-led health and adult social care organisations are and has found that the quality of leadership closely correlates with the overall quality of a service.<sup>46</sup>**

Governance arrangements give the organisational oversight to make decisions such as how resources are allocated, workforce is managed, risk is identified and problems are anticipated and managed. The review found that where this was working well, providers and CCGs routinely monitored performance such as waiting times, the quality of referrals and significant events. Good governance tools and processes support openness and were common in all areas with strong leadership.

In contrast, where there were concerns about leadership in CLAS reports, services had a range of governance issues that undermined the organisation's quality and safety; from poor data quality or a lack of staff meetings and supervision, to out-of-date guidance and policies due to a lack of appropriate auditing. This was evident at provider, CCG and trust levels. In most

areas, there were recommendations for at least one provider to review governance arrangements.

Significant complexity in commissioning processes and arrangements, as well as contract monitoring, acted as a barrier to solving many local issues, such as the provision of care for looked after children placed out of area. These issues were as prevalent in recent reviews as those inspected soon after CCGs were formed. To address these issues, there is a need for robust organisational oversight, clarity of roles and responsibilities and strong leadership across health systems.

### Workforce and capacity

Despite staff working hard to protect and promote children's health and wellbeing, the review highlighted widespread workforce and capacity concerns. The areas that were managing well worked creatively to ensure their services had the right staff and skill mix in place. For example, succession and contingency planning was used to anticipate and address workforce issues. Although locum, bank and agency staff can be vital to avoiding short-term gaps in provision, over-reliance on temporary staff affected resource management and consistency of care. Where workforce planning was not being done proactively, this affected the quality of training, supervision and quality improvement activity.

A significant issue was that of capacity for designated and named professional roles that provide safeguarding expertise and leadership through health and multi-agency partnerships. In England, designated professionals for safeguarding are statutory roles.<sup>47</sup> In addition, every health provider is expected to have a named nurse, doctor and midwife (where applicable) to support and effectively coordinate safeguarding activities. However, many areas were unable to fill posts, and where posts were filled, the professional was often stretched beyond their capacity. These concerns spanned across designated professionals for safeguarding, those for looked after children and named professionals.

One contributing factor was a lack of clarity of the role and responsibilities. CCGs are expected to employ designated doctors and nurses for safeguarding children, as well as for looked after children, or secure their expertise through an appropriate service level agreement (SLA) with a provider organisation. The SLA should set out the practitioner's responsibilities and what support they can expect to help them fulfil their designated role. Our review found that in practice this was not always the case. The responsibilities for looked after children professionals are outlined in an intercollegiate framework, but again this was not always clearly agreed at a local level.<sup>48</sup> Where professionals lacked clarity in their role, this made it more difficult to prioritise competing demands or manage their workload efficiently. Another concern noted was that individuals shared several posts, which limited their ability to fulfil all their required functions, such as governance and audit arrangements.

A knock-on effect of not managing capacity was on continuous quality improvement. Strides in making improvements to services were often hampered by lack of capacity of individual staff, exacerbated by insufficient supervision to support and sustain improvements. Where continuous quality improvement was achieving measurable impact, the work was part of a rigorous programme of multi-agency audit, which identified the areas for development and both support and supervision was in place to drive improvement across multiple services.

### LACK OF CLARITY IN ROLES AND RESPONSIBILITIES OF LOOKED AFTER CHILDREN DOCTORS

In one area there were two designated doctors for looked after children, but the commissioning and service delivery arrangements for these posts were unclear. The doctors' roles were not underpinned by clear job descriptions and there were inadequate arrangements to ensure that looked after children had timely initial health assessments. An unacceptable inequity of service was being delivered to some very vulnerable young people.

While individual practitioners had been aware of and raised concerns about the gaps in the service, this has not led to action, as there had been inadequate governance and a lack of management oversight or prioritisation of the situation for some time.

### STRONG SAFEGUARDING LEADERSHIP

Designated professionals were represented at the two trusts' safeguarding board in Stockton on Tees and were an integral part of the safeguarding governance and reporting framework. The LSCB had formed a multi-agency learning lessons and an improving practice sub group. The designated nurse was the vice chair. This group was managing the investigations of a recent spate of incidents across member organisations and monitoring the progress of actions against agreed action plans.

The executive nurse and designated safeguarding children professionals provided clear and effective leadership on safeguarding children practice. Key professionals and the designated safeguarding team met weekly to embed safeguarding awareness across the CCG.

## Training and supervision

Staff who work with children in healthcare settings should be trained to the level recommended in intercollegiate guidance for children.<sup>49</sup> Yet in almost all areas, the review identified concerns about safeguarding training in at least one service.<sup>v</sup> There were inconsistencies in the content, provision and uptake of safeguarding training across health services.

Training content was good where it included updates on topical subjects, was responsive to the needs of staff, and covered local and regional protocols and pathways, such as the multi-agency risk assessment conference referral process. Training provision and uptake were effective where the programme was delivered regularly in a multi-agency setting with support to ensure staff attendance.

### INADEQUATE SUPERVISION ARRANGEMENTS ACROSS ALL SERVICES

In one area significant gaps were identified in supervision across several agencies, including midwifery services, CAMHS, adult mental health, health visitors and emergency departments. For example, community midwives were holding on to many cases that involved significant safeguarding concerns. On reviewing the notes, inspectors found drift in some cases and a lack of clarity in child protection processes. In another service, there was no evidence of formal supervision and no clear action planning recorded in patient records. The report recommended that supervision practice be strengthened for all healthcare staff in this area and that discussion and action plans from supervision be clearly documented in the patient records.

Supervision arrangements were also variable. Supervision allows the opportunity for challenge and reflection, strengthening casework and

supporting the child and their family. Where supervision was effective, it was delivered in a number of settings including individual, group and reflective practice sessions. On the other hand, where supervision was not prioritised, staff lacked confidence and cases were not given sufficient direction. This led to drift and was a barrier to timely intervention in child safeguarding concerns.

Local safeguarding children boards (LSCBs) have a duty to scrutinise the safeguarding arrangements of agencies and undertake statutory and non-statutory reviews. They play a role in developing policies and guidance, providing training, and supporting information sharing between and within organisations. The review found on the whole that health engagement in the work of LSCBs was good. This was strengthened by:

- Close working with CCGs, and across the health system, including senior managers, designated and named professionals, CAMHS and practitioners from community child health.
- Arrangements for monitoring performance, such as attendance at child protection case conferences, uptake and attendance of safeguarding training, and multi-agency audits to identify areas for development.
- Identifying and recommending priorities for development in certain areas, such as self-harm and child sexual exploitation.
- Agencies being effectively held to account for outcomes in safeguarding, including reviewing reports on key performance targets.
- Having robust systems for taking on board the outcomes from learning events, particularly serious case reviews.

An active NHS England Area Team was also important to providing strategic direction and support across an area and encouraging continuous improvement in safeguarding procedures.<sup>w</sup>

v. 46 of the 50 reports noted at least one provider where we had concerns about the safeguarding training provision, uptake or learning.

w. NHS England Area Teams are now Local Offices of NHS England.

## EFFECTIVE LEADERSHIP ACROSS HEALTH

Strong and effective leadership was underpinned by improvement-driven senior health managers and named professionals in Cheshire West and Chester. Priority was given to partnership working: open, mature, supportive and challenging working relationships were noted between health organisations and with the local council and police service at a number of levels.

The two CCGs were innovative and collaborative in their approach, and had clear contract management and performance monitoring arrangements in place. NHS England Area Teams and CCGs were working closely together, and with the Council's Public Health team, to implement NHS reforms. The Safeguarding Forum met regularly and had made good progress in addressing its development agenda.

The NHS England Area Team provided good strategic direction and peer support for the work of designated professionals, including in strengthening their capacity.

Health engagement in and support for the work of the LSCB and its working groups was good. Local health commissioners were being effectively held to account by the LSCB for the delivery of quality improvements. Recent peer review work with LSCB members involved 'walking the floor' and seeing at first hand the safeguarding practices of other agencies, reflecting a positive learning culture.

## COMPLEX COMMISSIONING AND DELIVERY ARRANGEMENTS FOR CAMHS

In one area, all four CAMH services (tiers 1-2, 2-3, 4 and specialist services for looked after children) were each commissioned by and provided by different organisations.

Tier 3 services had recently undergone significant change and reconfiguration, compounded by long-standing recruitment issues. Vacant posts meant the team had limited capacity to respond to the demands, leading to extensive waits for initial assessments and access to services. There was a lack of a clear pathway or single point of access for CAMHS that would support timely decision-making or signposting to alternative services where young people do not meet the threshold for a specialist service.

Young people presenting with self-harm in A&E departments were not routinely offered admission. Arrangements that were sometimes made were to age-inappropriate general wards. Due to lack of appropriate facilities, especially at tier 4, children were experiencing long inpatient stays. With insufficient alternative provision locally, practitioners were struggling to provide an appropriate package of care.

On inspection, a number of cases were seen where referrals to CAMHS had not been made due to a lack of confidence in the service.

These widespread problems in the delivery of children's mental health services were of great concern. An intense focus from the CCGs on performance and management across the services was starting to lead to improvement, but much work remained to be done to improve access for young people to much-needed support and therapy.

## RECOMMENDATIONS

The way in which an organisation is led has a significant impact on the safety and effectiveness of care for children. A lack of oversight has knock-on effects on workforce and capacity, supervision and training, and ultimately the delivery of safe, high-quality care. In the current challenging climate, financial resources cannot be the only answer. The solution should involve every level in health from NHS England, Public Health England, CCGs and executive leadership roles to the frontline health staff who should be supported in their roles to keep children safe.

In practice this means:

- Designated professionals for safeguarding children and looked after children have their roles, responsibilities and accountabilities explicitly defined in job descriptions, aligned with expectations laid out in statutory and intercollegiate guidance.
- Commissioners and providers ensure designated and named professionals are in post and have sufficient resources, supervision and support to enable them to fulfil their responsibilities effectively.
- Commissioners and providers plan effectively to ensure the right staff resources are in place to meet the challenges across the system, which goes beyond simple numbers and includes skill mix, deployment, support and staff development.
- Training and supervision are prioritised across health systems to ensure that staff have the right skills and experience to best protect children.
- Commissioning arrangements have robust accountability structures for child health and safeguarding, with clarity given from the Department of Health where this has been uncertain, such as who is accountable for implementing the lessons learned from a serious case review.
- Leaders engage with their staff, as well as with children, to build a shared ownership of quality and safety that embeds a culture of quality improvement, and they are supported to deliver improvements.



## Conclusion and recommendations

The findings from the CLAS reviews highlight that health services are not consistently protecting and promoting the health and welfare of children. The unwarranted variability across the health system is very worrying. Much more must be done to listen to and involve children, ensure that services are improving outcomes, strengthen the quality of information sharing and joint working, and identify and protect those at risk from hidden harms.

Going forward, services should not simply react to new and emerging forms of abuse and harm to children, but be constantly aware and up to date with information available about risks. This information should feed into regular multi-agency training programmes and contribute to the continual evaluation of services.

Commissioners and partners must engage with children to fully understand their needs and concerns, and then use that information to design and provide the required services. Only then will they be able to monitor outcomes with much greater confidence that they are properly meeting the needs of their young population.

A key priority for the future is redressing the importance of prevention. Services must not lose sight of neglect, not least because it is the most common reason for taking child protection action in England.<sup>2</sup> When resources are limited it seems all too easy to lose focus on supporting those who would benefit from early help and

support, when problems are only just emerging. The importance and effectiveness of early intervention cannot be overstated and must be addressed with urgency for the safety of our society's most vulnerable children.

Many examples of good and outstanding care have been championed, which should encourage and inspire those working in the health system to realise the possibilities of what can, and should, be achieved in child safeguarding and for looked after children. The recommendations in this document provide a framework for commissioners and providers to drive improvement in their services.

## RECOMMENDATIONS

### **The child's voice: the silence is deafening**

- All health staff seek, hear and act on the voice of the child. They should involve children at each stage of their health care planning, and listen and respond to their views about what is important to them.
- All providers and local authorities empower children in meaningful ways to feed back on their experiences of care, with a particular emphasis on how the service is helping to improve their health and wellbeing.
- All children are involved in giving feedback on and co-designing their local services, ensuring they are as accessible and relevant as possible.
- All practitioners, providers and commissioners listen to the children who do not necessarily have a voice, including those with complex and severe developmental, physical, emotional and mental health needs.
- CQC continues to seek and report on the experiences and views of children who use health services as part of our single and joint-agency inspections.

### **The 'so what' factor: improving outcomes for children**

- Health services prioritise meeting the needs of children who would benefit from help and support early on, including those who do not meet the threshold for child protection proceedings, but have still been identified as benefiting from further support.
- Health assessments and reviews in all settings follow the Department of Health's guidance to ensure they are focused on action and outcomes for children.
- Screening tools for emotional health and wellbeing, such as strength and difficulties questionnaires (SDQs), are completed annually for every child in care, meaningfully contribute to their health reviews, and are routinely monitored to inform the impact of interventions. Those with abnormal scores are reviewed by an appropriate mental health specialist.
- All health services work collaboratively with children to determine locally-relevant outcome measures, in order to regularly evaluate the impact they are having. These measures should be used to track changes in outcomes (including emotional wellbeing) over time and inform resource allocation and service planning.

### **Quality of information sharing in multi-agency working**

- Providers ensure that healthcare staff are trained in how to articulate the risks identified to a child and made aware of local policies. This should be delivered at a multi-professional level to improve understanding of how each agency uses information.
- Healthcare staff across agencies strengthen relationships through joint training and regular contact in order to nurture trust and work together more effectively.
- Providers develop clear guidance and templates to standardise the information that is shared where appropriate, such as case conference reports, and embedded into practice. Referrals and reports are regularly audited for quality assurance.



- GPs are supported to better contribute to child protection meetings and case conferences. This may include improved flexibility in arrangements such as time, format, location, notice given and use of technology.
- GPs contribute to case conferences, even when they are unable to attend, for example by providing a comprehensive report that is discussed with the social worker or conference chair ahead of the conference date.

### **The five 'P's that support multi-agency working**

- All areas have compatible electronic systems that are able to reliably flag concerns and share information about vulnerable children and families across sites and agencies. In unscheduled care services, this should include implementing the **Child Protection – Information Sharing (CP-IS) project**.
- All services have processes in place to coordinate the follow-up of concerns about children, particularly in unscheduled care settings. A named individual(s) should ensure that these processes are regularly audited and reviewed.
- All agencies have jointly agreed protocols for dealing with the situation where a child is not brought to an appointment.
- Providers of minor injury units review the effectiveness of their child safeguarding arrangements and ensure that they meet appropriate standards.

### **Finding the hidden child**

- Significant improvement is made in embedding Think Family in all adult health services, particularly in adult mental health services, to consistently consider the needs of any children in contact with a service user, who might be at risk of harm.
- Improved recording of all relevant information about children and families, integrated IT systems that facilitate the sharing of information, and closer joint working, information sharing and training between adult and children's services.
- A family perspective is developed at all levels of health, including policy and performance indicators, in order to make progress in the Think Family approach.
- CQC ensures that Think Family is embedded in our inspection approach across all adult health services, including mental health services.
- All healthcare staff are enabled to take the time to build trusting relationships with the children and young people they work with, in order to create the environment for them to find out about issues that could be hidden from view.
- Health services appoint a lead person for both CSE and FGM who is responsible for ensuring that cases of CSE and FGM are appropriately handled, monitored and recorded.
- Standardised, multi-agency training programmes and supervision are available to all staff working in health. This should include how to identify risks and signs of CSE and FGM, how to ask the relevant questions of children, and how to escalate concerns. It must include UK law on reporting FGM.
- There are multi-agency policies and pathways and information-sharing arrangements in place to protect those who are at risk of CSE or FGM, or have undergone FGM.

- Services seek to understand and meet the physical, mental and emotional health needs of those who have been victims of CSE and women and girls who have undergone FGM.
- Commissioners and local safeguarding children boards identify the risks in their local communities, working with the voluntary sector organisations and those who have experienced CSE and FGM, so that their response meets the needs of their communities.

### **Transitions and access**

- The recommendations in *From the pond to the sea* are taken forward for all services to improve young people's experience of the transition from paediatric to adult services. In addition, those who do not meet the threshold for adult services, particularly in mental health, are offered alternative support.
- Looked after children who are moved out of area (or are returning to their home area) have robust arrangements in place for continuity of health reviews and are given priority to continue to access the health services they were previously receiving.
- Looked after children's services provide a comprehensive document (such as a health passport), to include a joint plan for their physical and emotional health, access to relevant information, and local options for additional support. Their care history should be summarised and include early and family histories.
- CAMH services receive the necessary funding and support to be able to meet the rapidly rising demands. This must be supported by improved identification and support of mental and emotional health problems for all children at an earlier stage.

### **Leadership**

- Designated professionals for safeguarding children and looked after children have their roles, responsibilities and accountabilities explicitly defined in job descriptions, aligned with expectations laid out in statutory and intercollegiate guidance.
- Commissioners and providers ensure designated and named professionals are in post and have sufficient resources, supervision and support to enable them to fulfil their responsibilities effectively.
- Commissioners and providers plan effectively to ensure the right staff resources are in place to meet the challenges across the system, which goes beyond simple numbers and includes skill mix, deployment, support and staff development.
- Training and supervision are prioritised across health systems to ensure that staff have the right skills and experience to best protect children.
- Commissioning arrangements have robust accountability structures for child health and safeguarding, with clarity given from the Department of Health where this has been uncertain, such as who is accountable for implementing the lessons learned from a serious case review.
- Leaders engage with their staff, as well as with children, to build a shared ownership of quality and safety that embeds a culture of quality improvement, and they are supported to deliver improvements.

## Appendix A: CLAS reports for local authority areas included in the analysis for the review

- Barnsley
- Bath and North East Somerset
- Bedford
- Birmingham
- Brent
- Cambridgeshire
- Cheshire West and Chester
- Cornwall
- Coventry
- Cumbria
- Darlington
- Derby City
- Devon
- Doncaster
- East Riding of Yorkshire
- Essex
- Gateshead
- Gloucestershire
- Harrow
- Herefordshire
- Hertfordshire
- Kent
- Kingston on Thames
- Lincolnshire
- Luton
- Middlesborough
- Newham
- Norfolk
- Northamptonshire
- Nottingham City
- Reading
- Redbridge
- Rochdale
- Rotherham
- Salford
- Sandwell
- Sheffield
- Solihull
- Somerset
- South Gloucestershire
- Stockport
- Stockton on Tees
- Swindon
- Thurrock
- Torbay
- Wakefield
- Waltham Forest
- West Sussex
- Wiltshire
- Worcestershire

## Appendix B: Organisations represented on the expert advisory group

CQC is grateful for the time, support, advice and expertise given to the review by representatives from the following organisations.

- Association of Independent LSCB Chairs
- Barnardo's
- Clinical commissioning groups (nine areas)
- Department of Health
- Department for Education
- Designated Professionals Network
- National Children's Bureau (NCB)
- National Society for the Prevention of Cruelty to Children (NSPCC)
- NHS England (Children and young people, safeguarding and mental health directorates)
- Office of the Children's Commissioner
- Ofsted
- Primary Care Child Safeguarding Forum
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- The Who Cares? Trust

## Appendix C: Template for reflection and action plan for continuous professional development CPD

(name)

has read CQC's national report on the review of the arrangements for safeguarding children and health care for looked after children in England.

(Date)

(Time taken for reading and reflection)

What have you learned?

What additional learning needs have you identified (personal and organisational) and how will you address these?

How will reading this report change your practice and have an impact on those you work with? Consider how you might evaluate this.

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