

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

## Children Looked After and Safeguarding The role of health services in Worcestershire

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<b>CCGs included:</b>	NHS South Worcestershire Clinical Commissioning Group. NHS Redditch & Bromsgrove Clinical Commissioning Group. NHS Wyre Forest Clinical Commissioning Group.
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## Summary of the review

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

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

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## About the review

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

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

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 123 children and young people.

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## Context of the review

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The majority of Worcestershire residents are registered with three main clinical commission groups (CCGs); NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG.

Children and young people under the age of 20 years make up 22.4% of the population. 10.8% of school children are from a minority ethnic group. Infant and child mortality rates for Worcestershire are similar to the England average. Six of the 32 ChiMat Indicators for Worcestershire were significantly worse than the England average: this includes immunisations for children in care, children achieving a good level of development at the end of reception, family homelessness, teenage mothers, smoking status at the time of delivery and breastfeeding initiation. Nine of the 32 indicators for Worcestershire are significantly better than the England average including GCSEs achieved (5 A\*-C English and Maths), children in poverty under 16, children killed or seriously injured in road traffic accidents, children with one or more decayed teeth, A and E attendances (0-4 years) hospital admissions caused by injuries (0-14 years).

The level of child poverty in Worcestershire is better than the England average with 14.9% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average.

Children in Worcestershire have average levels of obesity: 9.5% of children aged 4-5 years and 18.4% of children aged 10-11 years are classified as obese.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. Children in care equates to a similar rate to the England average. A lower percentage of children in care are up-to-date with their immunisations

There were 340 children aged five to 16 years who had been looked after for at least 12 months in 2014. Of these, 90 (26.5%) had a Strengths and Difficulties Questionnaire (SDQ) score compared to the England average of 68.1%. The average score in Worcestershire was 15.2, higher than the England average of 13.9, and a score which would represent a borderline cause for concern.

*Commissioning and planning of most health services for children are carried out by **NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group**. This is delegated to the Worcestershire County Council Children's Commissioning Team through a section 75 agreement.*

*Acute hospital services are provided by **Worcestershire Acute Hospitals Trust (WAHT)***

*Commissioning arrangements for looked-after children's health are the responsibility of **Worcestershire Children's Commissioning Team** and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by **Worcestershire Health & Care NHS Trust (WHCT)***

*Health visitor services were commissioned by **NHS England** but transferred to public health on 30 September 2015 and provided by **Worcestershire Health & Care NHS Trust***

*School nurse services are commissioned by **Public Health** and provided by **Worcestershire Health & Care NHS Trust***

*Contraception and sexual health services (CASH) are commissioned by **Public Health** and provided by **Worcestershire Health & Care NHS Trust***

*Child and Adolescent Mental Health Services (CAMHS) are provided by **Worcestershire Health & Care NHS Trust***

*Adult mental health services are provided by **Worcestershire Health & Care NHS Trust***

*Child substance misuse services and Adult Substance misuse services are commissioned by **Public Health** and provided by **Swanswell***

*Specialist facilities Tier 4 CAMHS are provided by **NHS England***

*The Worcestershire integrated inspection into Safeguarding and Looked After Children's services (SLAC) was carried out in October 2010. The report found that the overall effectiveness of safeguarding services in Worcestershire was found to be inadequate, though the capacity for improvement was adequate.*

*In relation to health at the time, there were a total of 10 recommendations made in the report with seven recommendations to be carried out within three months:*

- Provide a CAMHS out of hours in patient service for all children and young people up to the age of 18 years requiring this.*
- Develop the alert systems used in accident and emergency departments to include a flagging mechanism where safeguarding concerns apply.*
- NHS Worcestershire to develop more robust monitoring systems for the safeguarding responsibilities of all independent contractors.*
- NHS Worcestershire to ensure formalised arrangements are in place for the monitoring of the quality of health care provided to looked after children in out of area placements.*
- NHS Worcestershire to recruit and appoint a named GP.*
- NHS Worcestershire to ensure business plan for improvements to CSA examination facilities is implemented.*
- Worcestershire Mental Health Partnership NHS Trust to ensure targets for level 1 safeguarding training are achieved.*

*Within six months of the report, a further three recommendations should have been carried out:*

- Improve involvement in training and participation by GPs in safeguarding and child protection responsibilities.*
- NHS Worcestershire PCT to develop and implement care pathways for children and young people with ADHD and ASD.*
- NHS Worcestershire to ensure that the views of young people are heard in the planning and development of health care services.*

*Ofsted held an inspection of safeguarding services in Worcestershire in March 2012. The overall effectiveness of the services was found to be adequate, as was the capacity for improvement.*

*The last inspection of health services for Worcestershire's children took place in November 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review and included the following:*

*NHS Worcestershire should ensure that appropriate arrangements for strategic leadership and operational delivery and monitoring of health services for children looked after and care leavers are put in place.*

*NHS Worcestershire and Worcestershire Health and Care NHS Trust (WHCT) should ensure that the health needs of children looked after and care leavers and the services they require are reflected in strategic and operational plans to improve outcomes.*

*Ensure that pathway planning and review, include planning to meet health needs is timely. Effective and meaningful to the young people involved.  
Expand the range of opportunities for the views of children, young people and care leavers to inform service development and delivery, including in relation to their health care.*

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## The report

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

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## What people told us

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We spoke to some parents who told us that they had used the Minor Injuries Unit services on several occasions with their other children.

They told us:

*"The service is very good, absolutely fine. We are usually seen very quickly, don't have to go far for an X ray if one is needed and are always given follow up appointments if they are needed".*

We spoke with the young person who had just received care and support from a nurse. They told us:

*"The nurse was really nice. She spoke to me most of the time rather than my mum and that made me feel good. I know what I can and can't do now until I get better".*

A new mother on the post-natal ward at Worcester Royal Hospital:

*"I had the same midwife throughout my labour, she was fab!"*

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## The child's journey

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

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### 1. Early help

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- 1.1 Children and young people attending Worcester Royal Hospital emergency department (ED) are seen promptly. Practitioners recognise the need to ensure children and young people are prioritised where clinically appropriate and are not kept waiting in the department for long periods.
- 1.2 Children and their parents or carers wait in a dedicated child friendly waiting area. The waiting room is locked and can only be accessed by staff. This helps to ensure the safety of any child or young person waiting in there. However, the children cannot be easily seen or monitored by nursing or medical staff and therefore the potential for a deteriorating child to be missed is possible. The trust are intending to install CCTV, however, we were not assured that a firm date for this had been agreed.  
**(Recommendation 2.1)**
- 1.3 In the cases sampled, the safeguarding triage section of paediatric and adult paperwork was not routinely completed and on occasion, whether the adult was a carer for a child was contradictory to information within the notes from the ambulance service. A full assessment of the impact of a parent's risk taking behaviour on the wellbeing of children within a household cannot be completed unless this information is gathered and considered. **(Recommendation 2.2)**
- 1.4 Children and young people who attend emergency care at Worcester Hospital first book in to reception where their demographic details are taken. Insufficient care is taken in accurately recording full names and status of next of kin and who is accompanying the child. Poor information recording at this early stage is a feature of serious case reviews. **(Recommendation 2.2)**
- 1.5 All attendances of children and young people to the Worcester Hospital are routinely shared with the GP. However, there was no sign in the paediatric waiting area or waiting areas at the minor injury units to let families know that this information sharing happens routinely. **(Recommendation 2.3)**

- 1.6 Paediatric liaison is effective and supports ED well in reviewing all attendances of children and young people at both EDs and the minor injury units across the county. Where paediatric liaison identifies missed opportunities to refer children to children's social care, then this is either discussed with the practitioner if they are on shift, or with the named nurse. There is no opportunity, however, to share this learning with the wider ED team.
- 1.7 Young people who attend ED at Worcester Hospital following misuse of alcohol or substances do not benefit from a co-ordinated multi agency approach. There is no formal liaison with the local young people's alcohol and substance misuse agency. This is a missed opportunity to identify and support a young person engaged in risk taking behaviours through early engagement with treatment agencies. (**Recommendation 2.4**)
- 1.8 ED practitioners are not routinely using paediatric case notes for young people aged 17 despite this being trust policy. The use of paediatric case notes for these young people is important in reminding practitioners that there may be additional vulnerability that should be considered as part of their assessment. (**Recommendation 2.5**)
- 1.9 Children and babies attending ED and Minor Injuries Units (MIU) are not routinely weighed; the use of weights to calculate centile growth and ensure correct dosage of some prescription medicines is important. Recording weight is a baseline observation and should be routine so that any divergence from growth centiles can be monitored and acted upon. (**Recommendation 2.6**)
- 1.10 Expectant women access maternity services through their GP practice either with a GP or directly with a community midwife. We saw evidence that midwives have a flexible approach to conducting antenatal appointments, including booking in a variety of settings, including the woman's home address. Where midwives identify an expectant woman with social vulnerability they are able to refer to the Early Help Hub with the woman's consent. We were shown data that indicates increased numbers of expectant women are being referred for early intervention. This is positive.
- 1.11 Assessment of risk within midwifery services is not sufficiently robust. Risk assessment tools are integrated within the handheld maternity records. Although in most cases sampled, the risk assessment tools were completed at booking, they were not routinely repeated later in pregnancy even where risks had been identified. In order to ensure a woman's care is individualised, their circumstances should be reassessed to inform and adapt their plan of care according to changes in need during pregnancy. (**Recommendation 2.7**)

- 1.12 It is a trust expectation that midwives screen for domestic violence at least three times during a woman's episode of care: However, in notes seen there is insufficient evidence to show that any routine enquiry regarding domestic violence is being undertaken. Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy: In the cases seen we were unable to confirm that staff are identifying women who are experiencing domestic violence and referring them to appropriate support services. **(Recommendation 2.7)**
- 1.13 Police notifications of domestic violence incidents were seen within maternity notes sampled. We were told that maternity services routinely receive all police reports where women are pregnant or recently postnatal. We were told that midwifery is represented at Multi Agency Risk Assessment Conference (MARAC) meetings and we saw evidence of MARAC information within maternity records.
- 1.14 We were advised that adult mental health practitioners routinely develop indicators of mental health relapse and crisis plans with their clients. When shared with other professionals, these can help other services identify early signs of relapse and ensure early help is put in place. However, during the course of our inspection we did not see any evidence of health relapse plans being used or shared, for example, with health visitors. **(Recommendation 4.8)**
- 1.15 In CAMHS we were told that all choice (first) appointments are offered within an 18 weeks' timeframe from referral. This is a Key Performance Indicator (KPI) which is reported upon monthly to commissioners. Further information in relation to CAMHS will be addressed later in this report.
- 1.16 New parents are well supported by health visitors who carry out key visits as part of the healthy child programme. We were informed that the Ages and Stages Questionnaires are now being used to help inform the 2 ½ year development review. Any child who has missed a 2 ½ year development review will be identified as a universal plus case. The universal plus service offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting. This is good practice as it encourages practitioners to remain vigilant and alerts them to potentially vulnerable families.
- 1.17 Due to capacity within teams, health visitors are currently only undertaking antenatal visits on a targeted basis. Health visitors have created an office based antenatal folder, which helps to maintain a log of vulnerable mothers who require an antenatal contact. It is important that all families, irrespective of identified vulnerabilities, are offered and receive antenatal contacts. The lack of repeated risk assessment by midwives means that emerging risk may not be identified and if health visitors are only targeting known vulnerability for ante natal visits there are potentially missed opportunities to identify and respond to emerging need early. **(Recommendation 2.9)**

- 1.18 The health visiting team benefit from support from nursery nurses, where one to one task focussed work can be delegated, in particular around behaviour management. However we heard that there is an inequity of nursery nurse support across Worcestershire and we were told that there are plans to review.
- 1.19 School nurses provide a range of services. There is good use of social media to promote health education by the school health team. The use of Twitter and the planned use of a text messaging service means that young people will be able to access support and guidance in a format with which they are familiar. In response to a school health profile assessment, school nurses are providing targeted input that includes helping children in primary schools develop coping skills and strategies. This is intended to help prevent them engaging in risky behaviours when transferring to high school.
- 1.20 Young people have access to contraception and sexual health (CASH) services in both generic and young people specific clinics running between Monday to Friday, including a Saturday morning service. Good outreach services are provided in different venues to reach those young people that are as identified as vulnerable and need a more individual targeted approach. This is good practice as young people have access to sexual health advice and support in locations and venues that they feel the most comfortable and with ease of access. However, from records we could not be assured that assessment for potential risk of sexual exploitation was being carried out with sufficient rigour or detail. (**Recommendation 3.1**)
- 1.21 We were informed that a senior nurse will review records of any young people who have failed to attend sexual health appointments and a referral made to the CASH outreach team for follow-up. This was not evidenced in records seen; we were told that although the services are integrated across the sites, the IT systems are separate on each site and no arrangements have been made to cross check or share information between the sites. (**Recommendation 3.2**)
- 1.22 Children are afforded early help access in respect of drug or alcohol use. There is a specialist young people and family team with workers who focus on the needs of children and young people from the age of five upwards to include support to those children who may be affected by parental drug and alcohol use. The service has only been commissioned since April 2015 and is still in the process of promoting services across the county. All children who access the service have a care plan, risk assessment and are given details about information sharing. This is good practice and evidenced in files.

- 1.23 In adult substance misuse services provided by Swanswell a Think Family model of practice is embedded and the needs of children considered as part of the assessment process. The comprehensive IT system includes red flags to identify a child in the household or contact with children, violence, self-risk or medication. This means that workers accessing the system have immediate access to potential areas of risk of harm and impact upon children.
- 1.24 In adult substance misuse services, staff routinely link with other services including food banks and housing to monitor the impact of drug and alcohol use on the family. This is good practice and demonstrates professional curiosity being used as a means of ensuring the welfare of children.
- 1.25 The Multi Agency Safeguarding Hub (MASH) has only been operational for three months and has yet to be reviewed and evaluated. However, the system appears to be working as a basis for signposting referrals where it is unclear which service they should be referred to. The functioning of the MASH is due for first review in October 2015.
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## 2. Children in need

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- 2.1 Children and young people who attend ED for emergency support for their mental health, who self-harm or who take an overdose are quickly seen and assessed by CAMHS during normal working hours. However, for those young people who attend out of normal working hours, the service is less responsive: Some young people are assessed by the all age mental health liaison team who work in the ED up to 10pm each day but for other young people who are admitted to the paediatric ward, especially over weekends and bank holidays there can be a delay in accessing specialist CAMHS support. There is no access to a CAMHS consultant outside of normal working hours and this is poor practice. (**Recommendation 4.1**)

- 2.2 The Worcestershire Health and Care Trust support CAMHS patients on the paediatric ward well. A multi-agency urgent mental health care pathway has been implemented across Worcestershire to ensure a co-ordinated approach in supporting children, young people and their families who present in emotional distress or crises. We heard how the pathway is helping to ensure that children and young people receive an assessment, care and treatment in an appropriate environment. The pathway includes escalation processes to minimise inappropriate stays on paediatric wards and delays in accessing specialist CAMHS in patient care. Staff in ED and the paediatric ward spoke positively on the impact of the pathway. These vulnerable young people are usually admitted into a dedicated clinical area that has been risk assessed and made “safe” and ligature points removed. A number of care pathways and care plans have been agreed to support paediatric nursing staff in caring for this cohort of patients until a formal CAMHS assessment has taken place. This is good practice.
- 2.3 The specialist midwives for women with additional needs and vulnerability provide safeguarding advice and support colleagues and are caseload holders for the most complex cases within their teams. We saw evidence of the specialist midwives conducting home visits, liaising with relevant services, sharing information, and working jointly with social workers to ensure that vulnerable women are well supported.
- 2.4 There is a NICE compliant perinatal mental health pathway in place for women with an identified high level of need. Support for women with low to moderate mental health issues is provided by GPs, the community mental health team and children’s centres, although there are long waiting lists for some of these services. In some cases seen we were not assured that mental health needs were appropriately identified or responded to. In one case there was no mental health referral despite evidence of a high level of need. In another case low level issues were identified but no planned support or monitoring was evident in the records. (**Recommendation 2.10**)
- 2.5 Enhanced services have been developed in the identified geographic area of highest need within the county. However, it is not clear that any good practice or valuable learning from these services has been disseminated to practitioners elsewhere within the county. For example, here is a joint midwifery/substance misuse clinic in the North of the county. However, this service is not replicated elsewhere and this has been recognised as an area for development. (**Recommendation 3.3**)
- 2.6 We were informed of an innovative project for teenagers in Kidderminster called “teenage parents to be” which provides an enhanced service for this population group. It is reportedly well attended and evaluates well. The project has been expanded to include postnatal groups for teenage parents.

- 2.7 Adult mental health practitioners with special interest in specific areas of care and support are encouraged to develop and share their knowledge within the team. Specialist interest 'champions' include work in domestic violence, mother and baby care and CAMHS transition to adult services. However, the service is practitioner dependent and not part of a commissioned specific role and therefore at risk of not being a sustained service provision. (**Recommendation 4.3**)
- 2.8 The 'Think Family' approach is evidenced in adult mental health records but not embedded as expected standard practice and reliant upon individual practitioner professional curiosity to ensure family information is up-to-date, relevant and used to inform the risk assessment process. (**Recommendation 3.4**)
- 2.9 The health visitors send welcome letters to every family and child who is under five years and moves into their area. The letter contains details regarding an initial health visitor appointment that has been arranged for them by the service, as well as information and details of health clinics locally. This is good practice as it is an opportunity for early assessment of need and encourages engagement with services.
- 2.10 There is a pathway in place to handover and transfer care from the health visiting to school nursing service. For those families and children who are vulnerable or have more complex needs a telephone handover is arranged and in certain cases a face to face handover is arranged. Whilst a face to face handover would be deemed best practice for all cases, we were told that the agreed practice is due to the geographical challenges of Worcestershire. The detail of case handover was not evidenced in records seen.
- 2.11 The Family Nurse Partnership programme in Worcestershire is still in its early development stages and is therefore too early to review the impact.
- 2.12 Each GP in Worcestershire has allocated link named health visitors attached to their practice. We were told that in most GP practices there are regular safeguarding liaison meetings, and are an opportunity for the multi-disciplinary primary care team to discuss any families of concern. However, this good practice does not extend to all GP practices and this means that some vulnerable and more complex families may not receive a co-ordinated approach to their care. (**Recommendation 1.3**)

- 2.13 There are currently no specialist health visitor roles in Worcestershire; however there are a number of health visitors who have ‘specialist interests’. These practitioners are available to the wider health visiting team for advice and support. Although this supports practice it means that the service provision is practitioner dependent and therefore liable to change in the event of staff changing roles. Good, well-resourced health visiting services can help ensure that families have a positive start by cultivating the learning and practice that will enable strong safe service development. Health Champions to network with others in the same role, and with a combination of services and organisations involved as a platform to share best practice and to support local initiatives. **(Recommendation 4.3)**
- 2.14 We have seen good joint working between school nurses, health visitors and Looked After Children (LAC) nurses. This is good practice, as it demonstrates that there is good liaison between professionals to ensure there are positive outcomes for the most vulnerable young people within Worcestershire.
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### 3. Child protection

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- 3.1 Awareness of child sexual exploitation (CSE) is underdeveloped within emergency care and across the Worcestershire Acute Hospitals Trust. Training in raising awareness of CSE is underway; however, we saw no exploration or assessment of potential CSE in any ED cases reviewed. The trust has not yet identified any CSE champions. **(Recommendation 3.1)**
- 3.2 Most of the referrals we saw from midwifery to children’s social care do not contain any analysis of risk, the potential impact of parenting behaviour on a new born or the expected outcome of the referral in relation to the threshold document. Audit and quality assurance of referrals to children’s social care are not routinely undertaken and would be beneficial to help identify training needs for clinicians and strengthen child protection process. **(Recommendations 3.5)**
- 3.3 It is a trust expectation that midwives prioritise attendance at initial child protection conferences and provide reports for conference. In cases sampled we saw that the specialist midwives for vulnerable women provide detailed high quality reports and that midwifery representation at child protection conferences is good. Safeguarding information is held within hospital notes in a dedicated safeguarding section. The most up to date information/birth plan is placed in a “pink envelope” which is easily identifiable within the notes and ensures easy access for staff.

- 3.4 'Safeguarding around the time of birth plans', are jointly prepared by the social worker and midwife and were found within all relevant cases sampled. The plans are shared with the woman which is good practice. However, there is scope to strengthen the detail. For example; by including descriptors that would identify how specific vulnerabilities manifest and should be managed.
- 3.5 We were told that in the case of Interim Care Order applications or parenting assessments, it is usual practice for a mother and baby to be placed in the transitional care unit for up to five days in order to await the outcome. Extended in-patient stays for medically fit women and babies for social reasons are not appropriate. (**Recommendation 2.11**)
- 3.6 Adult mental health practitioners prioritise attendance at child protection meetings. In all cases examined we saw that the minutes of such meetings were included within client files and outcomes went on to inform the care planning process. Adult mental health practitioners advised us that they are routinely invited to attend and inform both pre-birth and post-birth discharge planning meetings. This is good practice.
- 3.7 Tier 3 plus services are sometimes known as assertive outreach/or intensive community services and are designed to provide enhanced support for children and young people on the boundary between needing Tier 3 and Tier 4 services. In Worcestershire, CAMHS Tier 3 plus services are provided as a means of supporting children at home pending a tier 4 in patient placement or specialist foster placement or in attempt to prevent the need for hospital admission. However, the service operates during office hours Monday to Friday and therefore support to this vulnerable group of children and their family is limited. (**Recommendation 4.1**)
- 3.8 We were informed that health visitors receive an e mail acknowledgment of receipt of all referrals that are made to children's social care and that this is routinely documented. However health visitors are reliant upon paper records and in records reviewed we saw no evidence of referral or documented outcomes to or from social care. We were told that is because electronic referrals cannot be printed to enable filing in the paper health records. We were not reassured that any attempts have been made to rectify the problem and this means that health visitors safeguarding records are incomplete and there is currently no management oversight of the number of referrals made to children's social care and therefore no quality assurance process. (**Recommendation 3.5**)
- 3.9 Information sharing between health visitors and midwives is good. However we were informed that information is only likely to be shared with adult mental health practitioners during more formal child protection processes. This gap has been recognised and work is currently underway to develop a pathway between health visiting and adult mental health practitioners. Poor inter-service communication is a feature in serious case reviews. (**Recommendation 4.8**)

- 3.10 A CSE screening tool is in use across the County and although the tool is being used by school nurses, it not widely used across other health services and this means that practitioners may not readily identify potential or actual sexual exploitation of children and young people. (**Recommendation 3.1**)
- 3.11 School nurses told us that they are routinely notified of attendances at ED of children and young people and that those notifications are received in a timely manner. However, in one case examined a young person attended ED following overdose on 2 July 2015 and the attendance was notified to the school health team on 14th July 2015 but the discharge summary was not received until 27 July 2015. Although the young person is now regularly seen at school drop-in sessions, there was a risk that the young person might not have felt that there was support available due to timely interventions not being put in place. At the time of our review the case was being examined by the provider to ascertain the reason for the delay.
- 3.12 We examined cases where reports prepared by school nurses were provided to inform child protection conferences and these were comprehensive and aided by the routine use of chronologies to better inform practitioners of significant events.
- 3.13 In records reviewed we saw evidence that outreach workers from CASH were attending CSE strategy meetings, which is good practice as they are in a unique position to provide expert advice to facilitate the most vulnerable young people being protected from harm. We heard that the outreach team leader and safeguarding named nurse attend the CSE panel meeting, where an overview of cases takes place. We saw no evidence of case discussion within the records reviewed. However the service is reliant upon the use of paper records held at different venues and this is a risk. We were told that there are multiple sexual health records for young people within Worcestershire and that staff do not have ready access to all records held. It is therefore unclear where information is being filed and how that informs on going work with the young person. We were told that there are plans to roll out a new electronic patient record across Worcestershire. (**Recommendation 3.2**)
- 3.14 GPs we spoke to were confident in how to refer a child or family to children's social care and on the purpose of the Early Help Hub for those families that do not meet the criteria for child protection. GP practices visited had appropriate processes in place to ensure that requests for reports for child protection conferences were responded to. Where a GP practice had received child protection conference minutes, these were being uploaded onto the patient's record. (**Recommendation 1.2**)
- 3.15 Not all GP practices have a 'did not attend' (DNA) policy at their surgery. This is not good practice and means that vulnerable children and young people who might not attend for appointments can be overlooked and the opportunity to recognise risk missed. (**Recommendation 1.2**)

**Case Example:** one GP told us how when he receives a notification that a child has not been taken for a hospital appointment he telephones the parents or carers to ask why and rearrange the appointment. If he is unable to make contact by telephone he will make a visit to the family home to ensure that the child's non-attendance is addressed and a new appointment made.

- 3.16 In drug and alcohol services workers are expected to attend child protection meetings, core groups and reviews and always prepare a report. In files seen records indicated regular communication with other services and practitioners and minutes from meetings.

**Case Example:** a young person who lived with her mother due to her parents having separated was made the subject of a child protection plan. As a result of the plan the young person moved from one part of Worcestershire to another to live with her father. A school health nurse from the new area took over the care and support of the young person.

Prior to the young person moving a full health assessment was undertaken by the school health nurse. Once the young person had moved in to their new home a further health assessment was undertaken by the school nurse taking over the case. The assessment was comprehensive and highlighted a health issue that was affecting the young person's ability to remain in class for acceptable lengths of time, develop relationships with new friends or partake in sports.

The school health nurse liaised, with the young person and their parent's permission, with their GP who prescribed medication which helped the young person remain in class, develop friendships and partake in their favourite sports. The school health nurse has developed good working relationships with the young person and both parents identifying the needs and likes of the young person and taking them to core groups to advocate for the young person.

The young person is no longer the subject of a child protection plan and is developing well at school.

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## 4. Looked after children

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- 4.1 The numbers of children and young people receiving timely initial health assessments remains an area of concern. Although performance in timeliness is increasing, there are still many children waiting too long for this important assessment. The introduction of key performance indicators and reporting of breaches and reasons for delay are all escalated to the corporate parenting board but performance remains poor. This is of significant concern and evidence of an enduring problem in Worcestershire that has been previously subject to CQC action plans. (**Recommendation 5.1**)
- 4.2 All initial health assessments are carried out by paediatricians and this is in line with statutory guidance. However, the quality of assessments and recommendations for health care plans are inconsistent. We saw examples of assessments that did not explore social vulnerability, emotional health and wellbeing or risk taking behaviours, especially in the older children and young people. In some cases seen, issues identified in the health assessment did not feature in the recommendations for the health care plan. This then led to this information being lost and some health issues for children never being followed up and resolved. (**Recommendation 4.4**)
- 4.3 Babies and children coming into the LAC care system identified for potential adoption for the most part had some parental health information within the initial health assessment and this is good practice. However, in most cases where adoption was not being explored as an option, parental health histories were not included in the initial health assessment, although it may have been available to social care at the point the child came into care. As a result, this important information may be lost to the young person. Young people and care leavers repeatedly tell us that this information is important to them as they enter into adulthood and its absence can have long reaching effects. (**Recommendation 4.6**)
- 4.4 Appropriate arrangements are in place to ensure that looked after children and young people placed out of Worcestershire benefit from initial health assessments and health reviews. Cases seen showed comprehensive assessments that clearly outlined the health needs of the child or young person.
- 4.5 Looked after children identified as needing support from the CAMH service are supported by a dedicated care pathway. Recent data shows that there are no looked after children waiting to receive a CAMH service and the corporate parenting board maintain an oversight on the numbers of LAC referred to the service and any waiting times.

- 4.6 Good support is available to support children and young people in residential care homes. An innovative “team around the home” service has been developed and supports young people who live in a group home. The LAC nurse is a key member of the team of professionals who support a young person in residential care.
- 4.7 Children and young people do not always benefit from comprehensive, holistic reviews of their health needs. The quality of health reviews is variable and, for the older children, often episodic with no evidence of the child’s health journey. Practitioners carrying out health reviews are not referring to information from other professionals working with the child or young person and using this to inform the assessment. (**Recommendation 4.4**)
- 4.8 We saw no evidence of strength and difficulties questionnaires (SDQs) being used to measure or monitor the emotional health and wellbeing of a child. This is a lost opportunity for the SDQ to inform the health assessment as well as the opportunity for older looked-after children to use their SDQ to track their own emotional growth. (**Recommendation 4.9**)
- 4.9 In most cases seen the emotional health and wellbeing of children and young people is not being sufficiently explored or recorded. This lack of exploration extends into risk taking behaviours and we saw no consideration into CSE for some very vulnerable children and young people. (**Recommendation 4.10**)
- 4.10 Young people we spoke to felt that their health reviews were something that happened to them and their overriding memory is of having their height and weight measured. Consent is being sought from some young people where this is age appropriate, however, this is not routinely happening. Also, young people told us that they are not offered the choice around where their health review takes place. These are important factors in involving young people and encouraging them to take increasing responsibility for their own healthcare. (**Recommendation 4.4**)
- 4.11 Support for older young people and care leavers is good. Young people aged sixteen and over benefit from the support of a specialist LAC nurse who works specifically with this age group. We saw evidence of how she works creatively with those young people who are reluctant to engage with health professionals. Health files seen contained health reviews and recommendations around future health needs for some young people who have a history of non-engagement. Some of these reviews are carried out over a protracted period of time and although out of statutory timescales the quality of the work is good.
- 4.12 However, young people leaving care are still not benefitting from a healthcare summary. Health files are being created and kept by foster carers and residential home staff, however, this information is not being collated into any meaningful summary that a young adult can use and refer to. (**Recommendation 4.7**)

- 4.13 Care leavers are benefitting from a range of dedicated supported accommodation where they are able to access 24 hour support. The LAC nurse for 16+ works closely with staff and young people resident in these settings.
- 4.14 Young people who are looked after are able to access CASH services from the sexual health outreach team. The family nurse partnership (FNP) has just launched across Worcestershire and there are ongoing discussions about the referral process for any pregnant LAC or care leaver.
- 4.15 Most GPs we spoke to did not have a well-developed understanding of the health needs of looked after children, the statutory framework surrounding their health care or legal issues on consent. Initial health assessments and health reviews do not benefit from the input or involvement of the child's GP. The GP is the key record holder and may have important information to contribute. (**Recommendation 4.5**)

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## Management

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

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### 5.1 Leadership and management

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- 5.1.1 A multi-agency urgent mental health care pathway has been implemented across Worcestershire to ensure a co-ordinated approach in supporting children, young people and their families who present in emotional distress or crises. We heard how the pathway is helping to ensure that children and young people receive an assessment, care and treatment in an appropriate environment. The pathway includes escalation processes to minimise inappropriate stays on paediatric wards and delays in accessing specialist CAMHS in patient care. Staff in ED and the paediatric ward spoke positively of the impact of the pathway.

- 5.1.2 Insufficient resource and priority is allocated to safeguarding children within the Worcestershire Acute Hospital Trust. This means that the trust board cannot be assured that practice is effective. The capacity of named professionals is insufficient for a trust of this size. The absence of the statutory role of a named midwife to lead and prioritise safeguarding has impacted on governance, management oversight, audit and quality assurance, all of which is needed to improve, develop and standardise practice, particularly record keeping, training and safeguarding supervision within midwifery services. There is no named midwife in post but we were told that an appointment has been made and the post holder will commence on a part time basis with effect from November 2015. This is a new post to cover Worcester Royal, Alexandra Hospital and Kidderminster Hospital. **(Recommendation 2.13)**
- 5.1.3 There are plans to introduce a network of safeguarding link staff across the Worcestershire Health and Care Trust, however, to date no formal role descriptors have been developed and no additional resource allocated to the role. This lack of investment will significantly impact on the effectiveness of any network developed. **(Recommendation 3.6)**
- 5.1.4 Awareness of safeguarding and child protection within GP practices visited was good. The legacy of an historical drive to improve communications with the multi-disciplinary teams continues in most practices and in one practice was exceptional. However, information sharing with school nurses was consistently weak; GP practices recognised that contributions to discussion from school nurses is often missing: One practice told us that although they always send invitations to school nurses to attend the practice's multi-disciplinary vulnerable meetings they are never able to attend. This is a missed opportunity to share valuable information.

**Case Example:** *In one case seen the head teacher at a school had spoken to the mother about the child's repeated absences from school for minor illnesses. The school staff had had asked the mother to seek a medical note from the GP to verify the child's absences.*

*The mother had approached the GP who had reviewed the child and told the mother clearly that a medical note would not be provided because the child was well and should be attending school and that as a parent she should ensure her child's education. The GP discussed the situation with the head teacher. The parent took on board the advice of the GP and the child has since not been absent from school.*

- 5.1.5 In two GP practices visited all GPs had undertaken their Level 3 training in safeguarding children. However, GP practices do not appear to be routinely using the RCGP toolkit for safeguarding children and the LSCB toolkit for CSE. These are important tools that support primary care in identifying, supporting and protecting vulnerable children and families. **(Recommendation 1.4)**

- 5.1.6 The LAC health team, though employed by the Health and Care Trust are part of a multi-agency team that work to support looked after children and young people. IT systems are shared across agencies and this helps to ensure that records are up to date and access to the most up to date information is available to practitioners.
- 5.1.7 The CCG has been unable to recruit to the post of named GP. The decision has been made to appoint two part time named professionals in line with NHS England guidance on alternative named professional models to cover the role. These are due to commence their roles in the near future. However, GPs told us that they were unaware that the named GP role existed and had not been filled since March 2014. They went on to say that they were not aware of the role having been advertised.
- 5.1.8 The designated nurse has been providing support to primary care since the named GP became vacant. Each GP practice has a lead safeguarding GP. Good progress is being made with GPs attending safeguarding training, with 50% increase in update over the past twelve months. The training has multi-agency input by police and children's social care.

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## 5.2 Governance

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- 5.2.1 Audit on safeguarding practice across the Worcestershire Acute Hospital trust is underdeveloped and the recently formed safeguarding children sub group has limited attendance from some divisions across the trust.  
**(Recommendation 2.12)**
- 5.2.2 In ED, notes not always clearly signed and dated with the clinician's designation stated. This is not compliant with the professional requirements for record keeping.
- 5.2.3 Inspectors noted a lack of awareness by ED staff on the role of the Local Authority Designated Officer (LADO). In records seen inspectors identified two records where a referral to the LADO would have been appropriate.  
**(Recommendation 2.14)**
- 5.2.4 There is no regular opportunity for ED staff to discuss safeguarding practice within the department. Although there are regular governance meetings and a paediatric meeting, safeguarding is not a standing agenda item. This means that feedback on the learning from referrals, serious case reviews and other issues is limited to dialogues with individual practitioners and not disseminated across the team. **(Recommendation 3.3)**

- 5.2.5 Governance around record keeping and care planning within health visiting is weak. Practitioners are reliant upon the use of paper records and limited access to the national spine. The trust is investing in a new IT system for patient records, this is essential in order to ensure updated and easily accessible information. Health plans reviewed were not SMART. Plans are mainly task focused or basic lists of appointments rather than setting out measurable objectives. Timescales are vague and accountabilities are not always appropriate and realistic to enable effective follow-up to ensure tasks are completed. (**Recommendation 3.2**)
- 5.2.6 There is currently no management oversight of young people's attendances at CASH that ensures that clinicians are completing risk assessments and assessing for Fraser competence. The lack of management overview of all attendances is a missed opportunity to ensure that all clinicians are making the right decisions regarding vulnerable young people. (**Recommendation 3.6**)
- 5.2.7 GP practices were using electronic flagging systems to identify vulnerability and child protection; however, these are not consistent across all practices. This may cause problems if a child moves GP practices across Worcestershire. In addition, there is no systematic way to notify primary care of children who are looked after, who are subject to child protection plans or families that are involved with MARAC. GPs told us that they rely on information sharing at the vulnerable multi-disciplinary meetings and also use any requests for information for child protection as an indicator to flag a record. (**Recommendation 1.1**)
- 5.2.8 In midwifery scanned records are not always complete on "easy notes". We found cases where child protection plans, child protection reports and core group meeting minutes were missing. We were informed that this problem is compounded by delays in receiving paperwork from children's services plus their recent decision to limit the information included in the post conference letter sent to professionals and parents. However if, as we were told, paper records are destroyed once they are scanned it is essential that a more robust system of ensuring records are complete is developed. It is essential that all health practitioners engaged with a family where child protection plans are in place have prompt access to the current child protection plan. (**Recommendation 2.8**)
- 5.2.9 In the looked after children's health team the lack of routine quality assurance for both initial health assessments and health reviews is contributing to the considerable variability in content of assessment and planning.

- 5.2.10 Recent reviews have indicated high referrer satisfaction with CAMHS single point of access (SPA). This is thought to be attributable to protocols to forward some referrals directly on to other appropriate services rather than returning them to the referrer. However, a Health Watch survey is indicating some concerns from young people and their families who have been referred to CAMHS but not offered a service. Inspectors heard similar complaints from GPs suggesting that further work is work required in relation to thresholds for CAMHS access. One GP spoke of their frustration at CAMHS to the point of “not bothering to make a referral” unless absolutely necessary as they seem to be routinely turned down”.  
**(Recommendation 4.2)**

**Case Example:** *Z and her mother visited the GP to ask for help. Z was displaying social anxiety, having panic attacks and was always tired. This was having an impact on her ability to go to school.*

*The GP referred Z to the CAMHS and two weeks later received a letter advising that Z did not meet the criteria for service and suggested that Z and her mother access the local “stronger families” support as there was no evidence of significant mental health.*

*The GP wrote back to the CAMHS advising that Z and her mother were already accessing “Stronger Families” but that her emotional health was still of concern. He asked that CAMHS review the decision.*

*A day later, the GP received a response, outlining that a CPN had attended a professionals group to discuss Z and her mother and that no mental health issues were disclosed at that time. The CAMHS practitioner suggested that the GP explore with the family how successful the parenting interventions had been and reiterated that the threshold for CAMHS had not been met. Z continues to present with poor emotional health and is receiving no support. Her attendance at school remains of concern.*

- 5.2.11 The SPA is used as a gatekeeping service for access to CAMHS. The process is reliant upon a single operational duty practitioner who is tasked to screen and signpost referrals and in cases seen the priority was to divert away from CAMHS in the first instance. Team work underpins safeguarding children and young people and the present system is not robust and leaves families and referrers without a clear understanding of the response and outcome. **(Recommendation 4.2)**
- 5.2.12 However, once referrals are accepted by CAMHS, children and young people have access to a range of specialist CAMHS. In cases seen children and young people were benefitting from intervention and support from CAMHS and this is positive.

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## 5.3 Training and supervision

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- 5.3.1 Training in safeguarding children across most services is underdeveloped. We have spent a significant amount of time in trying to understand the complexities of training in Worcestershire. The current terminology used to describe various levels of training is confusing and does not correspond with the training expectations as outlined in the intercollegiate guidance for healthcare staff 2014 Levels 1-5. (**Recommendation 3.7**)
- 5.3.2 Worcestershire Health and Care Trust have recently completed a training need analysis to reflect the intercollegiate guidance of March 2014. However, the trust is not yet able to report accurately on staff who have attended training at the appropriate level. There are still groups of staff who need to access Level 3 training. (**Recommendation 3.7**)
- 5.3.3 Training is currently delivered in house and via e-learning with the majority of maternity services staff trained to Level 2. The preceptorship package for newly qualified staff has no safeguarding or child protection competencies included within it. Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, inter-agency Level 3 training at specialist level (minimum of 12-16 hours over a 3 year period). Competencies should be in line with the intercollegiate document. Training to the appropriate level will help ensure that all staff are competent at assessing, planning, intervening and evaluating the needs of a new born and parenting capacity where there are safeguarding or child protection concerns. Amending the current preceptorship programme to include safeguarding competencies would aid the learning and development of newly qualified midwives and prioritise this essential element of their role at an early stage of their professional career. (**Recommendation 2.16**)
- 5.3.4 We were informed that the health visiting management team receive monthly training reports. The reports inform management of practitioners whose compliance with mandatory and safeguarding Level 3 training is about to lapse. Team leaders are notified of which practitioners need to book onto training. This helps ensure that all practitioners are accessing safeguarding training within the recommended timeframe. We were informed that the current safeguarding Level 3 training is LSCB approved and in line with the intercollegiate guidelines. However, we were informed that due to issues with accessing Level 3 multiagency safeguarding training, some practitioners have only had access to Level 2 training which has been delivered in house. All practitioners need to ensure they have accessed safeguarding Level 3 training so they are up to date with changes in guidelines and safeguarding practice/procedures. (**Recommendation 3.7**)

- 5.3.5 We were informed that all health visitors have access to specialist training, for example CSE. However, not all practitioners have accessed this training. There is currently no training available for female genital mutilation (FGM), however all practitioners have been circulated guidance on reporting any potential FGM cases. (**Recommendation 3.1**)
- 5.3.6 Adult Mental health practitioners, particularly those within psychiatric liaison, home visiting teams and assessment teams who have regular one-to-one contact with children and young people, are not routinely trained to Level 3 safeguarding as per intercollegiate guidance. This includes practitioners who routinely assess children and young people in mental health crisis out of hours in emergency departments across the County. (**Recommendation 3.7**)
- 5.3.7 We were informed that all CASH clinicians are attending Level 3 safeguarding training, which is in line with the intercollegiate guidelines. Clinicians receive automatic notifications four months and at one month before they are about to become non-compliant with mandatory training, which includes safeguarding Level 3 training. This is a good way of ensuring that all practitioners are accessing safeguarding training within the recommended timeframes.
- 5.3.8 In drug and alcohol services, all staff have completed Level 3 safeguarding training and in addition the senior management board meets quarterly to review serious case reviews and lessons learned in the context of how they might apply to Swanswell staff and the information disseminated in staff learning workshops. Learning is tested via the supervisory processes and case audit. This is good practice. Safeguarding supervision is a standard agenda item in staff supervision. Records of the agreed actions are documented in the clinical notes. This ensures that there are clear lines of accountability. Reflective practice sessions are part of the work force development. Staff told us that they felt well supported and managed in being able to carry out their work.
- 5.3.9 The importance and benefits of multi-agency working could be usefully shared and reinforced by providing some joint training sessions.
- 5.3.10 Effective safeguarding supervision can play a critical role in ensuring a clear focus on a child's welfare. It is important that staff working with children and families are effectively supervised to support them and to promote a good standard of practice in safeguarding children. Supervision arrangements across Worcestershire are inconsistent not supporting strong effective safeguarding practice. (**Recommendation 3.8**)

- 5.3.11 We were informed that the Worcestershire Acute Hospitals NHS Trust are developing a safeguarding supervision policy and that they recognise that this is an area for development. Efforts have been made to identify and prioritise staff groups with the greatest need for safeguarding supervision which includes caseload holding community midwives. Safeguarding supervision is not currently offered within the maternity department of the Worcestershire Acute Hospitals NHS Trust. Advice and guidance is available to staff via the named nurse for safeguarding children or the specialist midwives for vulnerable women. (**Recommendation 3.8**)
- 5.3.12 Whereas health visitors and school nurses are receiving safeguarding supervision, adult mental health practitioners and CAMHS practitioners do not receive specific, structured 1:1 safeguarding supervision. We were advised that support and guidance can be sought by individual practitioners as and when required via the safeguarding team and evidence of this was seen in records. At other times support is obtained by way of regular peer group meetings where practitioners can discuss cases of concern. However, we did not examine any evidence of decisions made at such meetings being routinely recorded in client notes along with any actions used to inform the care planning and risk assessment process. The lack of 1:1 individual safeguarding supervision means that practitioners are not sufficiently supported to undertake their roles. (**Recommendation 3.8**)

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## Recommendations

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1. **NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group and NHS England should:**
  - 1.1 Support Primary Care in standardising user codes to identify vulnerability
  - 1.2 Ensure that all health professionals are aware of and adhere to the DNA policy.
  - 1.3 Work with GPs to help them to develop regular safeguarding liaison meetings.
  - 1.4 Support GPs in using the RCGP toolkit for safeguarding children and the LSCB toolkit for CSE.
  
2. **NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group and Worcestershire Acute Hospitals Trust should:**
  - 2.1 Improve observational facilities in ED through the installation of CCTV.
  - 2.2 Ensure that registration and risk assessment documentation which includes consideration of risk taking behaviours and potential for hidden harm is in place in the ED for both adults and children and that completion by clinical and non-clinical staff is subject to effective monitoring arrangements.
  - 2.3 Ensure that there are notices in the ED to inform parents of information sharing protocols.
  - 2.4 Ensure that an effective pathway is in place to engage young people who present at the ED with alcohol and substance misuse issues with appropriate support.
  - 2.5 Ensure that practitioners are using paediatric documentation for young people aged 17 compliant with trust policy
  - 2.6 Ensure that children who attend ED and MIUs are routinely weighed as part of a base line observation.
  - 2.7 Ensure that midwifery records demonstrate that discussions about domestic violence have been undertaken, recorded and concerns reflected in care plans and that a reassessment of vulnerabilities is completed during pregnancy in line with trust policy.

- 2.8 Ensure that midwives are proactive in ensuring that they have the up to date essential documentation to hand in order that their practice is best informed to protect the unborn infant.
  - 2.9 Ensure that all families, irrespective of identified vulnerabilities, are offered and receive antenatal visits by health visitors in line with best practice.
  - 2.10 Ensure that a clear pathway is put in place to provide a comprehensive assessment of risk to assess all pregnant women and to safeguard unborn babies. Outcomes should include clear care plans that will ensure planning for vulnerable women is strengthened to reflect individual needs.
  - 2.11 Ensure that medically fit women and their babies are not kept on hospital wards for extended stays for social reasons and that pre-birth planning is strengthened to ensure timely discharge to an appropriate placement if required.
  - 2.12 Put in place a robust system for audit of safeguarding practice and ensure cross trust representation on the safeguarding children sub group.
  - 2.13 Ensure that the capacity of the newly appointed named professional in midwifery services is developed to ensure audit and quality assurance to standardise practice.
  - 2.14 Ensure that all staff are aware of the role of the Local Authority Designated Officer.
  - 2.15 Ensure that midwives discussions with women about domestic violence are recorded and retained in records.
  - 2.16 Amend the current preceptorship programme for newly qualified midwives to include safeguarding competencies.
- 3. NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group, Worcestershire Acute Hospitals Trust and Worcestershire Health & Care Trust should:**
- 3.1 Ensure that a child sexual exploitation (CSE) strategy and implementation plan is in place, in accordance with local CSE arrangements, and that all health care staff are trained and familiar with FGM and the CSE toolkit and how to use it.
  - 3.2 Ensure that the plans to develop the electronic recording systems are implemented and include a review of all recording systems and record keeping that will ensure timely access to information, secure record keeping, family inclusive practice and quality assurance by managers.

- 3.3 Ensure that any good practice or valuable learning from services has been disseminated to practitioners across the county.
  - 3.4 Ensure that the Think Family model of working is embedded as a practice standard within all adult mental health services.
  - 3.5 Ensure that the Worcestershire Health and Care Trust safeguarding team in conjunction with operational managers routinely audit referrals to and outcomes from children's social care.
  - 3.6 Finalise and implement the plans for safeguarding links across the Trusts and ensure representation across divisions on the safeguarding children sub groups to ensure a robust system of audit of safeguarding practices.
  - 3.7 Standardise the safeguarding training arrangements and terminology to comply with the intercollegiate guidance for healthcare staff 2014 to ensure that staff are undertaking training at a level commensurate with their role and accurate records.
  - 3.8 Ensure that all health care practitioners are provided with regular 1:1 supervision and ensure that discussions and action plans from supervision are clearly documented in the patient records.
- 4. NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group and Worcestershire Health & Care Trust should:**
- 4.1 Ensure that children and young people who have mental health problems outside of office hours have access to services that provide a comprehensive assessment of their needs by suitably trained and qualified staff to inform the provision of appropriate care.
  - 4.2 Ensure that there is a cross sector agreement to ensure clarity of how CAMHS services are accessed or diverted to alternative support and that outcomes of referrals are given to young people and their families as well as the referrer in a timely way.
  - 4.3 Ensure that substantive posts include roles and dedicated time for special interest that will ensure continuity of practice and development of service.
  - 4.4 Ensure that all looked after children have timely and high quality holistic assessments of their physical, emotional and mental health needs informed by SMART health plans that ensure continuity of health care and which reflect the child's voice and age appropriate consent.
  - 4.5 Ensure that GPs are asked to contribute to initial and review health assessments for children in their practice and that family health information is transferred onto health assessment documentation as part of the process.

- 4.6 Ensure that work is undertaken with the local authority to ensure that parental health information is recorded as part of the initial and review health assessments of looked after children.
  - 4.7 Ensure that all young people who leave care are provided with a comprehensive health passport.
  - 4.8 Ensure that the information sharing pathway between health visiting and adult mental health services is implemented within a clear planned timeframe.
  - 4.9 Ensure that strength and difficulties questionnaires (SDQs) are being used to measure or monitor the emotional health and wellbeing of looked after children and young people as part of the review health assessment process.
  - 4.10 Ensure that health assessments of looked after children include the exploration of potential risk taking behaviours including CSE.
- 5. The Worcestershire Health and Care Trust and the Worcestershire Integrated Commissioning Unit should:**
- 5.1 Work with the local authority to improve timeliness of health assessments for looked after children.

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## Next steps

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An action plan addressing the recommendations above is required from **NHS South Worcestershire Clinical Commissioning Group, NHS Redditch & Bromsgrove Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group** within **20 working days** of receipt of this report.

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