Care Quality Commission

Review of Health Services for Children Looked After and Safeguarding in Hertfordshire

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

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Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence which could be checked in a number of 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 52 children and young people.

Context of the review

Hertfordshire is located just to the north of London, covering an area of 634 square miles, with a population of around 1.1m, making Hertfordshire one of the most densely populated shire counties in England. There are approximately 278,300 children and young people under the age of 19 years. This is 24.9% of the total population of Hertfordshire.

School-aged children and young people from minority ethnic groups account for 24.1% of the total population, compared with 25.4% in the country as a whole. 2011 Census information shows that the largest minority ethnic groups in Hertfordshire are Asian (6.5%), Black African and Black Caribbean (2.8%) and a notable Eastern European population (1.3%). The proportion of pupils with English as an additional language (11.6%) is below the national average (15.9%) with the main languages other than English being Urdu, Polish and Gujarati. There are ten district and borough council areas in the county. Watford and Stevenage are relatively densely populated wholly urban districts. East Hertfordshire and North Hertfordshire, outside their main urban towns, have large areas of rural countryside. The remaining districts of Broxbourne, Dacorum, Hertsmere, St Albans, Three Rivers and Welwyn Hatfield are more mixed. The 'Index of Multiple Deprivation' shows that Hertfordshire is consistently one of the least deprived areas of England; however, the general prosperity of the county is not evenly spread, and there are a number of pockets of deprivation and considerable variation across the county. All ten local authorities have pockets of considerable deprivation within their boundaries and a number of communities in Hertfordshire suffer from a range of elements of socio-economic deprivation, including child poverty, overcrowding and dependence on welfare benefits.

The spread of health services across a large geographical area produces challenges to information sharing across health and multi-agency partnerships. Hertfordshire faces several challenges with regard to both its geographic location infrastructure and transport networks. These can have implications that impact on safeguarding children, such as potential for movement through the county of children and young people who are trafficked, go missing or are at risk of child sexual exploitation.

There are two clinical commissioning groups (CCG) that commission health services for almost 250,000 children and young people across Hertfordshire; NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG. The CCGs are based on GP populations which cross ten district local authority boundaries as well as the one County local authority, facilitating partnership working which has a shared focus on the welfare of Hertfordshire children and young people.

NHS East and North Hertfordshire CCG commissions children's healthcare services from:

- The Princess Alexandra Hospital NHS Trust (not included in this review),
- East and North Hertfordshire NHS Trust,
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community NHS Trust.
- Barnet and Chase Farm NHS Hospitals Trust (not included in this review)
- Hertfordshire Urgent Care (not included in this review)
- East of England Ambulance Trust (not included in this review)

The designated professionals for safeguarding and looked-after children are employed by East and North Hertfordshire CCG on behalf of both Hertfordshire CCGs and NHS England. The designated nurse for safeguarding also has designated responsibilities for looked-after children. Hertfordshire Community NHS Trust is the provider for the health component for looked-after children.

NHS Herts Valleys CCG commissions children's healthcare services from the following providers;

- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community NHS Trust.
- East of England Ambulance Service (not included in this review)
- Herts Urgent Care
- West Hertfordshire Hospitals NHS Trust
- Barnet and Chase Farm NHS Hospitals Trust (not included in this review)
- Luton & Dunstable NHS Hospitals Foundation Trust (not included in this review)

The Hertfordshire Safeguarding Children Board (HSCB) is the key statutory mechanism for agreeing how organisations will co-operate to safeguard and promote the welfare of children. In 2012/13 it underwent a number of changes. The membership of the Board was revised and two lay members were recruited. Both CCGs and Hertfordshire and South Midlands NHS England Area Team are represented on the HSCB.

There were no serious case reviews (SCR) in 2012/13, but the HSCB undertook four partnership case reviews (PCRs) in 2012. A PCR is where cases don't meet the criteria for a SCR but there are still multi-agency lessons to be learnt from processes and practices. Recommendations and action plans were monitored by the HSCB SCR sub-group and by health. The key areas of learning from the PCRs for health were identified as risk assessments, communication and information sharing. These learning points reflect national findings arising from analysis of SCRs.

Watford General Hospital (West Hertfordshire Hospitals NHS Trust) has a paediatric emergency department, a paediatric ward, a children's day unit and a children's outpatient service. Additionally, the hospital has a special care baby unit (SCBU) and a private post-natal ward. This trust is applying to become a foundation trust.

East & North Hertfordshire NHS Trust which includes the Lister Hospital provides children's services comprising in-patient, outpatient, dedicated Children's Emergency Department, Neonatal Intensive Care Unit, community paediatrics and community nursing team services.

Community based services are provided by Hertfordshire Community NHS Trust. This includes health visiting and school nurse services, allied health care such as physiotherapy, occupational therapy and speech and language therapy as well as health services for looked-after children. The trust delivers the family nurse partnership programme and has a health transition service for young people with complex physical health conditions moving on to adult services.

Contraception and sexual health services (CASH) are commissioned by Public Health (Herts County Council). In North and East Hertfordshire it is provided by Hertfordshire Community NHS Trust and in the West by West Hertfordshire Hospitals NHS Trust.

The majority of Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT). HPFT also provide adult learning disability services. The CAMH services provided by the trust include specialist community CAMHS including an adolescent outreach team, A-DASH drug and alcohol service, a service for children and young people with complex neurodevelopment disorders, a 16 bedded adolescent inpatient unit, a forensic adolescent service, a targeted service for children who are subject to a child protection plan, on the edge of care and who are looked after and an early intervention psychosis team. Additionally this trust operates a mother and baby unit. Hertfordshire Community NHS Trust provides a Tier 2 psychology service and a challenging behaviour psychology service and a number of other agencies provide counselling and other Tier 2 support.

There are currently 308 Hertfordshire children placed out of county. Some are in placements on the county borders so they remain close to family and schools, this being preferable to remaining in county but at a potentially significant distance which could be more unsettling. There are 217 children placed in Hertfordshire from other local authorities.

The last inspection of health services for Hertfordshire's children took place in 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. At the time both the 'overall effectiveness of the safeguarding services' and 'overall effectiveness of services for looked after children and young people' outcomes were assessed to be 'adequate'.

In January 2013, Hertfordshire County underwent an Ofsted inspection for child protection. The 'overall effectiveness' outcome for child protection was assessed as 'adequate'. There is an action plan currently in place although most of the actions relate to social care. One of the actions does require GP's to ensure agency checks are returned to appropriate assessment teams, this action was not fully completed on the action log and the action was rated amber at the time of this CQC review.

The report

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

What people told us

The young people's council which works to improve mental health services operated by Hertfordshire Partnership University NHS Foundation Trust told us of their impact on service improvement;

"We are trying to change the leaflets for the trust's complaints procedure as they are not very child friendly. Engagement by the mental health trust with young people is improving. We are working on organising CAMHSFest which will have performances by bands and stalls to raise awareness about mental health. It will be open to schools and families to come along."

"The involvement officer is amazing. She'll get back to you if you can't talk to her straight away. The young people's council wouldn't exist without her."

"The clinicians are coming to our meetings of the young person's council and they are listening to us now. Posters have been changed and we now have a water machine."

"Young people should definitely be given the chance to be seen on their own without their parents when they are having a mental health assessment. It really frustrated me that I had to be seen with my parent. There should also be some sort of support to the parents as well."

“The involvement work has changed my life but the services haven’t really helped. I couldn’t get CBT (cognitive behavioural therapy) when I needed it.”

We heard about young people’s experiences of health support when they were looked-after children;

About health assessments;

“My health assessment was really good because I was a wreck when I came into care, really fat and they went through things and sort of chased me up every time about what I was eating.”

“They’re better now, instead of just going through a list and reading questions they make it a sort of conversation. But it depends who you get, if they’re experienced or not”

“Last time they came to my house to do it. I didn’t really want it there but you just go with it”

“My worker has given me stability. Everything else has changed but he’s always there.”

“You don’t get offered a choice of who to see or where. You get a letter or your carer tells you it’s happening. It’s not something you have any say about, it’s just a thing that has to happen.”

“Had a health check from the local GP this year when I came into care, he was really good, brilliant, not like other doctors, he listened to me, had a conversation first, didn’t sit typing on his computer. Listened to me, not anyone else”.

Young people were clear about the importance of having a sustained relationship with health service providers;

“I’ve seen CAMHS for several years, had the same worker, that’s really important, it took a long time for me to open up and I couldn’t start all over again.”;

We heard from some foster carers;

“I’ve always been very lucky with the health support I have had. The health visitors deserve gold medals”

“My local GP surgery will always fast track my foster child if I have to take him to the GP.”

“I don’t find the contact centre very respectful of my role as a foster carer but I do find that hospital staff treat me with respect and value my opinion and role as foster carer.”

“*I have requested that the paediatrician do the review health assessment which was due in October. It has been agreed that this will happen but I’m waiting for an appointment”.*

The child's journey

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

1. Early help

1.1 Health professionals described progress in understanding and co-operation across agencies to share information about children who are at risk. We saw some good examples where this secured improvements for children, for instance in the drug and alcohol services and midwifery. We also heard about good early help services based at the children's centres which are effective in supporting vulnerable families and children. We saw some effective partnership work of health practitioners, social care and schools to support families.

1.2 Targeted support for vulnerable and young women who are pregnant or become mothers is limited. A teenage pregnancy pathway is in place to ensure consistent contact from the specialist midwife 6-8 weeks before the due date but this does not extend into the post natal period. The provision of a family nurse partnership service (FNP) to support vulnerable young mothers is good practice; however it is only established in East & North Herts and not available to all young people who would benefit from this model of support. This has been recognised as a priority area for development by Herts Valleys CCG which is working closely with the Department of Health to address this gap in early help provision. Currently the existing service has no capacity to take on new referrals placing additional pressures on health visitor to give additional support to young mothers waiting for FNP.

1.3 We were told of long-standing concerns about the environment and capacity pressures in the post natal ward at Watford General. The ward was described by patients in the NHS patient choices survey as old and poorly equipped and staff lacking of time to provide full care for patients (recommendation 5.2). The ward undertakes post-operative care for a high number of women following caesarean sections and operates at full capacity. Practitioners told us that there are often staff shortages and staff are often required to support the delivery suite. The combined issues also making it difficult to get staff to work on the post natal ward due to the pace and pressure (recommendation 5.1).

1.4 Handover arrangements between midwives and health visitors are mostly effective but we did see some inconsistency. In health visiting we heard about some improved safeguards that are in place such as a visual check on babies' sleeping arrangements but capacity issues are impacting on health visitors' capacity to carry out other routine checks except for families already identified as the most vulnerable (recommendation 4.8).

1.5 In a range of community and acute health settings, we heard examples where the alertness of reception staff has picked up concerns and by doing so, safeguarded children. However, reception staff are not routinely ascertaining the relationship of the accompanying adult to the young person or establishing ethnicity, culture and language which could have implications for treatment (recommendation 7.5).

1.6 There are effective processes in place at all three acute sites to check all children accessing these services against the child protection plan database and we saw consistent and robust monitoring of paediatric presentations on a daily basis at all three locations.

Every child presenting at A&E is checked against the child protection plan listing by the reception staff at booking in. The CAS cards are all clearly marked as to whether a child protection plan is in place or not and if there are any other key risk issues immediately known such as the child coming from out of area.

Clinicians are immediately alerted *to any known potential vulnerabilities relating to the child which informs their own assessment of the child's situation and circumstances of their presentation for treatment.*

1.7 At the acute sites, Watford General Hospital, the urgent care centre and Lister Hospital, the number of the child's previous attendances appears on the CAS card as an automatic front page print out and staff use this as one of the risk indicators in relation to the child. However, at Lister Hospital, this number apparently resets to zero at the end of the financial year which could mean that this risk indicator information is lost and therefore there is inherent risk in the IT software as it stands. We heard that immediate remedial action was taken to address this issue and the problem has since been resolved. The introduction of a safeguarding tab on the case record and use of chronologies has helped to ensure key safeguarding information is clearly identifiable and accessible to staff, facilitating ongoing effective risk assessment.

1.8 We observed effective liaison between paediatric A&E nurses and other professionals to ascertain intelligence held by other involved agencies to inform the clinician's assessment of risks to the child. We heard an A&E nurse liaising well with a school nurse to illicit detailed information about the cause of an accident to a child, present in the department at that time and flagged as vulnerable as he had attended A&E on previous occasions. Risk assessment was effective and the potential safeguarding issue picked up appropriately and acted upon. Where a young person had accessed A&E having self-harmed, A&E clinicians were proactive in liaising with local CAMHS who knew the child and were able to secure the young person an appointment with the local service on the same day.

1.9 We also saw an example of effective risk assessment and follow up by the hospital safeguarding team of a vulnerable child from out of area.

Case example 1: *A child from Luton attended Lister Hospital A&E for a dog bite to his finger and received emergency treatment. The child left the department with a parent before treatment and assessment by plastic surgery clinicians was completed. The hospital tracked the child who later attended Addenbrookes Hospital for a head injury having run out in front of a car; and subsequently to Birmingham where he was found to have gangrene of the finger from the original bite that was not fully treated and followed up. Hospital staff referred the child to Luton's safeguarding team.*

1.10 The strong provision of a paediatric liaison service (PLS) in all three acute sites, reporting to the named nurse and providing daily reviews of all children presenting to A&E, is good safeguarding practice. Despite information barriers due to different IT systems, the provision of diligent safeguarding leads and health visitor liaison across the urgent care centre, Watford General Hospital and Lister Hospital A&E settings is a good safeguard.

1.11 The introduction of frequent checks by the PLS at Lister has dramatically reduced the occasions of discharges without a written summary by the consultant. The administrator screens all child presentations for discharge summaries and highlights any missing for quick identification. The PLS then follows these up with the discharging clinician for the discharge summary. Non-compliance is reported to the monthly leads meetings and followed up with individuals. As a result of these stronger arrangements, children are protected more effectively from the likelihood of any safeguarding issues being overlooked. Issues that need follow up by community health services are routinely being notified promptly. If discharge summaries were generated electronically, the system would be even more robust and effective.

1.12 At Watford General, early indications are that the rapid assessment (RAID) trial, which provides for a CAMHS nurse to be available in A&E each evening is helping to avoid the need for young people to be admitted overnight to wait for a mental health assessment. This is based on an existing model in adults' services and is a good example of the positive impact of joint operational meetings in addressing difficulties.

1.13 There is good liaison between adult and child A&E departments to share common issues and safeguarding concerns. In the adult A&E department at Lister Hospital, the initial screening form asks if there are any dependants and does pick up on any children who may be left at risk as result of the adult being in A&E. Risks to other non-dependent children living in the household with the adult are not routinely identified and the provision of specific trigger questions would strengthen the 'Think Family' approach (recommendation 6.2). We saw several examples of good identification of risks to children being made in adult A&E and referrals being made to social care. However, referrals are poorly articulated and do not set out clearly the actual risk to the child, even where the risks are well documented in hospital notes. This is a theme across health practitioners who are involved in the assessment of risk to children. This is not facilitating children's services making decisions most likely to deliver the best outcome for the child (recommendation 7.4).

Case example 2*: 35 year old female attended adult A&E for alcohol related issues and domestic violence- living with a partner with mental health problems. The couple have a 9 year old son with ADHD. Grandmother is living with the family. Whereas we saw appropriate identification of the implications of parental behaviour on the health and wellbeing of the son in the clinical record, these are not articulated clearly in the referral to social care.*

Case example 3*: Mother brought to A&E having overdosed. Her partner had gone to work leaving 2 children aged 12 and 6 alone with their unconscious mother. The elder child fetched their grandmother to look after the younger sister and went to school herself. The clinician had made an appropriate assessment of the risks presented to the children of this situation and these are well set out in the A&E records. A referral was rightly made to social care but this again does not clearly convey the situation nor articulate the potential impact on the children of what they had witnessed and been left to deal with.*

In both cases, it is not clear that social care would have had a full appreciation of the clinician's risk assessment and the potential impact on the child's wellbeing to inform their decision about intervention.

1.14 The weekly psycho-social meetings at both Lister and Watford review cases presented through A&E which have generated health visitor liaison activity. These help to identify sub-optimal practice, highlight good practice and ensure that any follow up action on individual children has been taken. Health staff told us that this is no longer attended by social care at Lister although their input had been valuable in ensuring discussions about individual children were fully informed (recommendation 1.3). We understand that social care continues to attend the meeting at Watford.

1.15 We heard that due to pressures on universal services, some babies and their families have difficulty accessing the early help they need, resulting in visits to A&E that should not be necessary. While the hospital emergency departments provide a service that the local communities value highly, practitioners told us that there is high attendance by Eastern European parents bringing children aged under 4 years with low level needs which could be seen by early help services in the community. Staff are not aware of any public health campaigns or information in other languages to encourage parents to seek advice and support from midwives or health visitors for issues such as feeding difficulties (recommendation 4.7).

1.16 We were told by staff in some services that child and adolescent mental health (CAMHS) services are difficult to access at times and some children wait a long time to get into services. However, cases we saw showed that CAMHS had responded promptly to referrals. It is not routine practice to give a Fraser competent young person the opportunity to be seen alone without their parent present when they are undergoing a mental health assessment. This may inhibit the young person in being able to express issues relating to their emotional health openly or to speak freely (recommendation 9.1) Seeing the parent separately from the child also may bring out useful information relevant to the situation and be a supportive mechanism for the parent. Once engaged with the service, we did see evidence of young people benefiting from the therapeutic relationship and practitioners who are committed to the young people that they see.

1.17 The assessment of risks to children has been strengthened in adult mental health through the introduction of an integrated single risk assessment tool. Practitioners told us that this is effective in prompting them to routinely consider children with whom the adult client has either parenting responsibility or regular contact and whether there are safeguarding issues which need to be referred. However, the cases we reviewed did not demonstrate that a *Think Family* [1]approach is yet embedded.

[1] A multi-agency programme established to improve outcomes for families where parents have mental health needs

1.18 The contraception and sexual health service (CASH E&N Herts) is run by Hertfordshire Community NHS Trust (HCT) which is a registered service, commissioned by Public Health. The service offers a range of dedicated sessions for young people and at variable times; practitioners work hard to engage young people who attend services and young people report that staff are friendly and approachable. We found that preventative and early help outreach services and capacity for targeted work in community areas of higher need are underdeveloped however (recommendation 8.5) Information on individual young people is shared with partners such as Connexions and practitioners make some further enquiries if concerns about individual young people are identified, however these are not sufficiently extensive. Information sharing and liaison with other services is not consistently recorded. The E&N Herts CASH IT system is stand-alone for reasons of patient confidentiality, but cross checking arrangements are not in place and this lack of rigor creates risk that not all relevant intelligence about a young person is secured effectively across the relevant partners (recommendation 8.6).

1.19 A-DASH provides an accessible, flexible service for young people who misuse alcohol or substances. A screening tool CRAFFT is well established and available on line. This asks six basic questions to identify concerns. CRAFFT is a simple and effective screening tool but it is not widely used by all relevant professionals working with young people. The service makes good use of current communication methods and has a range of quality publications with a modern brand style designed to engage young people. Managers in the service were unclear why referrals to A-DASH have dropped over recent months, particularly from youth offending and targeted youth support and from CAMHS (which have dropped from 15 to 7 since April). Commissioners told us they have a good understanding of the nature of this reduction, in that the number of young offenders in the population is reducing which is a positive outcome. The service told us that referrals from acute health services are also low, given the high level of young people attending A&E for drug & alcohol issues; this warrants further evaluation to ensure pathways are clear and appropriately used (recommendation 1.2). New adults' and children's drug and alcohol referral pathways are about to be launched and offer the opportunity to increase access to help for young people who misuse substances and this may resolve the recent drop in referral rates. A-DASH and school nurses work well in partnership to support the well-being of young people, although this area of work is challenged by the capacity pressures in the school nursing service. Young people's transitions into adult services are well supported and individually tailored to best support each young person within the framework of an effective protocol.

2. Children in Need

2.1 Maternity liaison meetings are well established and multi-agency with routine attendance by the safeguarding nurses from the HCT community health services. This facilitates effective communication of information to community services about babies and families where vulnerabilities have been identified at an early stage and the prompt initiation of CAF support.

2.2 The health visitor assessment template includes a section in which the health visitor sets out the service plan of action to support the family. This helps to promote good evaluation and clear planning. We saw some excellent practice from health visitors with most health visitors undertaking comprehensive risk assessments with additional assessments of the emotional health of the child. There was some variation however, for example safeguarding issues not being recognised and acted upon which were subsequently addressed following a change of allocated health visitor in one case. A number of cases we reviewed showed clear evidence of very beneficial outcomes for children where risks had been reduced as a direct result of the health visitor's intervention.

Case example 4*: a newly qualified health visitor took on an existing case and undertook a home visit to conduct a health check on the children. Although no concerns had been raised previously, the health visitor immediately identified significant environmental risks to the children. She reported these immediately to her supervisor and a referral was made to social care.*

As a result of this prompt action, the case was taken to an initial case conference which the health visitor attended, supported by her team leader and to which she submitted a written report on her concerns and their potential impact on the health and wellbeing of the children. All three children became subject to child protection plans as a result and continue to be protected.

Case example 5*: a single mother with a baby of 21 months and an older child with autism/Asperger's syndrome moved to the county to live with her mother and mother's partner. This move was prompted to escape domestic violence by her ex-partner.*

As he was missing his Dad, the elder child returned to live with his father. The health visitor to the children discussed the impact of domestic violence on children and contacted the health visitor service where Dad lived. They had not been aware of the previous domestic violence and contacted the school to make further enquiries about the wellbeing of the child. The school also had concerns and a referral was made to social care.

The child was made subject to a child protection plan and moved back to live with his mother. The younger child was also put on a child protection plan due to further changes in circumstances. MARAC was involved as a result of threats to the family by the ex-partner.

The elder child is engaged with CAMHS and doing well at school. The mother's relationship is stable and both children are now CIN rather than subject to child protection.

2.3 The graded care profile which has been introduced into community services will give a clear focus to the family, identifying strengths and resilience which can be built upon as well as areas which need to be strengthened and supported. This has been proven to be helpful to families where there are needs equating to CIN or CAFs.

2.4 Where CIN plans are scanned into the health visitor information system, they are difficult to access and as a result, the role and participation of professionals involved with the family may be difficult to easily identify (recommendation 4.6).

2.5 The Freedom Programme for survivors of domestic abuse is operated by a small team consisting of eight health visitors and children centre staff. This 12 week programme has been shown to have significant impact in helping mothers to develop coping mechanisms and demonstrate more effective parenting. Attendance at this group can be made a requirement of formal plans but this is done rarely as the best outcomes are achieved when the mother is well motivated to engage with the group rather than through compulsion. Alongside this programme runs the Cherish group, a peer support group which is also achieving good outcomes.

2.6 We saw a number of cases where risk has been carried by health practitioners in community services and mental health for a sustained period of time during which practitioners concerns had continually been raised with children's services using established escalation protocols. We saw examples where health visitors, GPs and CAMHS staff were constantly monitoring risks and vulnerabilities and taking responsive and prompt action, often collaboratively and supporting young people very effectively.

2.7 The bruising and bleed protocol and single fracture pathway are operating effectively, ensuring automatic referrals to the acute hospital for the child to be seen by the paediatric and orthopaedic teams. We saw good evidence of these pathways and protocols working in practice with a rapid and thorough assessment of a child's needs and CAF assessment opened at a multi-agency meeting the following day.

3. Child Protection

3.1 Health staff across all services have a clear and appropriate focus on the significance of child non-attendance at appointments and effective processes are in place to identify these with prompt action being taken to notify relevant partners.

3.2 We found a lack of clarity among staff across a number of services about the appropriate use of information sharing forms which should be used to inform a single agency, usually in community services, about vulnerabilities/concerns. In some instances, practitioners had completed information sharing forms in the belief that that they had made a child protection referral (recommendation 7.3).

3.3 The pre-birth protocol is being re-launched, it has been strengthened so that it is now mandatory that social care are represented at the monthly maternity liaison meetings whereas previously their attendance was hit and miss. Midwives describe prompt responses from children's services to their concerns about unborn babies. Their professional judgements about likely early deliveries are listened to and although late planning may happen, it is sometimes due to late registration of pregnancy. We saw examples of good practice across health and social care in pre-birth child protection work. In one case however, the midwife attending the birth was not aware of a pre-birth plan which was on the case file and stated clearly that the baby was not to be discharged. The midwife ascertained this directly from the duty social worker having spent a significant amount of time trying to contact social care. Although it is established practice that the named midwife puts a flag on the paper and electronic record to indicate the existence of a plan, this information had not been conveyed effectively in this instance although ultimately, the baby was protected effectively.

3.4 In the CASH service in addition to a lack of clarity of understanding among staff of the criteria for the use of information sharing forms or when a formal safeguarding referral should be made, we also identified further information sharing issues. Copies of information sharing forms are not kept routinely, not subject to managerial scrutiny or follow-up monitoring. To date there has been no auditing of safeguarding referrals by the service to monitor progress, identify trends or multiple risk indicators which may encompass a cohort of young people and assure continually improving quality (recommendation 8.4).

3.5 Three cases were referred back for managerial review. These cases had been referred to HCT's safeguarding team and one had been discussed with social care who had not identified any concerns about the young person. However, whereas there is no requirement for young people aged 13 -16 who seek contraception to be referred automatically to social care, two of the young people had originally presented to the service at 12 years and therefore this should have prompted automatic referrals. Following this review, managers in HCT planned to undertake a review of the service to ensure arrangements are in line with statutory guidance (recommendation 8.2).

3.6 The information sharing guidance operating across HCT was due for review in August 2013 and is not fully in accord with *Working Together* supplementary guidance. A practice example affecting CASH is that Working Together states there must be a recorded strategy discussion regarding any under 13's accessing the CASH service and this had not happened in the cases we identified. There are a number of other deficits within the current operating guidance; including a referral flow chart which does not differentiate between U13's and others under 16; the under 16s risk assessment tool is also insufficiently comprehensive in terms of potential hidden abuse indicators (recommendation 8.1).

3.7 Where chronologies of significant events for children in need and child protection were seen on community health practitioner records, these were used to good effect.

3.8 There are effective multi agency arrangements to identify and help young people who are at high risk of harm as frequent runaways or as victims of child sexual exploitation. These arrangements appropriately include third sector providers. WHHT undertake child protection medicals when the child is admitted to hospital requiring treatment. Approximately 40-50 children are admitted via A&E who go through the child protection process due to suspicions about their presentation. Approximately 10 child protection medicals are directed to A&E out of hours. A child abuse suite opened at PEACE in March 2013 and all other child protection and sexual assault examinations take place in this new facility.

3.9 We found that GPs understanding and ownership of their responsibilities and part in practical arrangements to share information is still too variable; some strong arrangements are in place but in other cases we heard that other professionals struggle because GPs are unaware of safeguarding protocols or are confused about the interface with patient confidentiality; in these cases, there is significant potential for risks to children being missed if the GP fails to convey key information promptly to the right agencies (recommendation 2.2).

***Case example 6**: Baby B aged 6 weeks, non-English speaking parents living with extended family. When the mother attended the six week post-natal check the GP's nurse noticed bruises on the baby. The GP referred the baby to the hospital, initially citing constipation as the reason.*

The GP referral also stated that the mother and baby had been sent to A&E with an interpreter (this later turned out to be her sister in law). This suggests that GPs need more awareness of the need for formal interpreters to overcome potential conflicts' of interest.

At the hospital there was difficulty in obtaining independent interpreting support but hospital staff are aware of the conflict of using relatives, and a hospital doctor was identified who speaks their language. The family did not give consistent answers and further investigations and enquiries were made by hospital clinicians. A full and thorough family history was taken by the interpreting doctor and full checks were made the next day at which point, the Police were notified.

The GP practice in this case showed good awareness of possible child protection concerns regarding potential non-accidental injury to the baby who was then seen promptly at A&E which enabled further investigation into the injuries although the GP did not make a safeguarding referral. The equally diligent response by hospital staff resulted in the baby being protected quickly from further harm.

***Case example 7:** a woman known to present risk to her children presented to the GP practice when 37 weeks pregnant, her partner told the GP not to refer to social care and was aggressive and threatening. The GP rang the midwife instead. The midwife immediately referred to social care. The couple had had scans done privately and hoped to stay under the radar.*

***Case example 8**: A mum had had nine children removed, then became pregnant again. The GP did not share this information with midwives until 26 weeks (contrary to guidance).*

In both cases, prompt action by midwives in referring to social care ensured these unborn children were protected.

3.10 Work has been undertaken to improve GP participation in child protection case conferences: a proforma has been developed by GPs, Hertfordshire County Council and the designated nurse to facilitate easily completion and optimise GP contributions to conferences. There is an agreement that the report template will be completed and submitted if the GP cannot attend. The chair of conference can follow up the submission of a report with a telephone call to the GP prior to the conference.

3.11 The safeguarding forum overseen by Hertfordshire and South Midlands NHS England Area Team proposes to develop a menu of actions that it is reasonable for a GP to be asked to do as part of a child protection plan. This has the potential to strengthen GPs contribution to the protection of children known to be at risk of harm. Where serious case reviews (SCRs) have been undertaken, GPs have engaged positively in the process with the support of the designated nurse.

3.12 The pathway by which social care requests a mental health worker to attend strategy meetings are directed to the correct mental health team and appropriate worker has been strengthened. All such requests go through a senior practitioner who expedites the request reaching the right person. In the cases we reviewed however, we saw variable safeguarding and child protection practice in adult mental health. We reviewed three adult mental health cases, from this selection one case demonstrated poor safeguarding and child protection practice, the other two showed that appropriate practice was being followed. Think Family approaches were not yet embedded and some practice exposed significant deficits within the service at both the frontline and in managerial oversight of practice.

***Case Example 9**: A mother involved with adult mental health since 2008, with four children. The youngest child was receiving support from CAMHS. A mental health support worker undertook home visits and recorded different versions of how the children were cared for given by the mother and father. These and other safeguarding risks had been observed and recorded but had not been recognised for their significance. The observations and risks had not been reported to either a senior social worker in the team or the overseeing psychiatrist and had not been acted upon. This could have had serious implications for the children in the family. There was not appropriate engagement and participation with formal child protection processes. There was an over reliance on the mental health support worker delivering the majority of interventions. Necessary changes to support in response to the mother's needs and the potential impact of her mental health on the child were not identified.*

The support worker attended the initial child protection case conference (ICPC) at the request of the mother for support. Whilst the support worker knew the mother well and was able to provide a valued contribution to the conference and the psychiatrist provided a written report, no registered professional attended to provide a professional opinion with regards to the impact of the mother's mental health on the child and the mental health service's contribution to the protection plan. The mental health report provided to conference was not in the patient records. The parent's mental health diagnosis was misrepresented at the case conference and was not challenged. The overall child protection plan lacked clarity and SMART outcomes and the adult mental health service was unclear on its role in the child protection plan.

The mother started to disengage from adult mental health support over a period of some months; she did not attend appointments and did not let the support worker into the house offering various excuses. She then held two meetings with the support worker in a café. In doing this, the mother has moved the professionals away from the house where there are children. No discussion took place between the support worker and psychiatrist about these events or their potential safeguarding implications for the children and there was no communication with social care.

Communication between CAMHS and adult mental health had been also lacking in this case. There had been stronger engagement by CAMHS in the child protection processes and they understood their role clearly.

We had concerns about the rigor of the child protection processes and joint agency working in this case and referred it back to health and social care for managerial review. Managers recognised and acknowledged the deficits in the case and took prompt remedial action to address our concerns and ensure the children were safeguarded.

3.13 In one case, adult mental health had worked with a young woman for some time before her case was transferred to a third sector provider for on-going support for her substance misuse. On receipt of a section 47 enquiry regarding concerns to an unborn when the woman was confirmed as pregnant, adult mental health provided good information about their engagement. The service also passed on contact details for the substance misuse complex needs worker who was engaged with the young woman. However, the substance misuse worker did not attend the ICPC and it is not clear whether the information from the mental health service had been followed up to ensure decision making was fully informed as there was no reference to the service in the minutes. In cases where there was an adult mental health worker and health visitor closely involved with a family, while there was liaison between the health practitioners with the social worker in the case, there was little or no direct contact between the key health workers. As each could provide the other with professional expertise which would help ensure more robust, co-ordinated safeguarding practice around a vulnerable child, this is an opportunity missed. An example being the mental health worker sharing indicators of potential relapse with the health visitor to inform her home visits and strengthen the multi-agency safeguarding risk assessment (recommendation 7.6).

3.14 We did see some clear and robust child protection plans in which health's role was set out clearly, but we also saw a number of cases where the child protection plan was not sufficiently SMART and health practitioners found it difficult to articulate their exact role.

Case example 10: *15 year old young person (child A). She is the oldest of four children and lives with her mother and father. In response to concerns that she was leaving the family home to spend time with an older male and risk of serious self-harm, her case was allocated to the disabled children's team who were already working with her sibling. Section 47 enquiries raised concerns regarding parental management of boundaries for child A, concerns regarding mother's mental health and concerns about neglect in relation to the state of the home. and the care of two of the other children. At initial child protection conference (ICPC) all the siblings were made subject to child protection plans.*

Multi-agency intervention is delivering positive change for the family. CAMHs intervention alongside social work support has assisted Child A to clarify her thinking. She is now re-engaged with school. Professionals supporting the mother are describing an improving picture in her mental health. Child A's father is much clearer in his thoughts, is working with the social worker to change the current situation. Issues around hoarding and the home environment remain a challenge.

Managers acknowledged that the child protection plan needs revision to make it 'Smarter' with clearer outcomes, measures and timescales, reflecting the risk and needs of each child in the family and the changes to parenting required to achieve this. This was addressed during our review. Work is also being carried out on the development of child protection plans that have clearer actions and outcomes. Best practice examples are being developed within the service.

3.15 We referred a number of cases back to health and social care for a management view of the effectiveness of the child protection arrangements. Having reviewed one case, it was acknowledged that an overly optimistic view was taken by all the professionals involved in the original core assessment, some of the risk predictors from research were not fully considered; and an earlier move from child in need to child protection status may have been a more accurate reflection of the risks. A number of actions were taken with the safeguarding teams as a result of this review to strengthen risk assessment practice and ensure assessments are appropriately signed off by supervisors. Key actions being taken included ensuring staff maintain professional scepticism when assessing families, consider all aspects of need, particularly when a parent is actually still a child themselves, consider the physical risk a mother may pose to their child even when they may also be the victim of abuse.

3.16 In a case where there was long-term neglect, concerns had been raised on a number of occasions by the health visitor who was applying the same agreed strategies repeatedly with the family. This had not achieved any identifiable change or positive outcome over a period of some months. Clearer summarising of the key risks and impacts on the children might have helped health staff to see the need for escalation sooner and more rigorous action could have been taken.

4 Looked after Children

4.1 We saw evidence that the looked-after children nurses know some children well and make committed efforts to engage hard to reach or challenging young people and encourage them to engage with services. Review health assessments undertaken by the looked-after children nurses reflect the voice and individuality of the child. In one case, it seems that over some years, the looked-after children's nurse represents one of the few constants in the young person's life and this is important to the young person.

***Case example 11**: a female looked-after child accommodated in secure provision since 2010 in an out of area placement. The child has had several changes of placement including a return into county at one point. Throughout this period the looked-after children's nurse has maintained contact with the young person and has seen her a number of times. During the recent review they were able to enjoy a shared memory about a previous health review.*

The young person has enjoyed a positive relationship with the looked-after children's nurse over a period of years and has been able to remain engaged with the monitoring of her own health and wellbeing as a result of this stability.

4.2 The foster carers we met spoke highly of the support from health visitors. One told us that "the baby loves the health visitor; he gets all excited when she comes. I trust her to be honest and open with me." Another had received training from physiotherapists so that she could apply therapeutic massage to a baby in her care and felt that she had always been very lucky in her health support.

***Case example 12**: A 17 year old male who became homeless due to family breakdown caused by his difficult behaviour and illicit drug use, his A-DASH worker kept in touch with him throughout and brought together the homeless service, targeted youth support and CAMHS which resulted in the young man gaining looked after status. To address the homeless issue he was placed in a local hostel. However his situation again deteriorated and he was involved in serious drugs and crime and was also the victim of violent crime.*

A-DASH contacted their commissioner about the risks and secured a drug rehabilitation placement for 2/3 weeks.

His situation has since improved and he continues to be supported by A-DASH within a community setting.

Effective joint working also identified a history of unresolved concerns including extreme bullying which contributed to the young man's earlier difficulties.

4.3 Overall however, the service to support the health needs of looked-after children is a priority area for improvement. Most assessments are not completed within expected timescales so there is risk that some children will enter and leave the care system without having an assessment of their health needs or services put in place to ensure their on-going health and well-being. We did see some good examples of assessments but the overall quality of initial and review health assessments that we saw was too highly variable and most were poor. Some were of unacceptably poor quality with little or no attempt to engage the child in the process and containing only the most basic health information (recommendation 4.2). In a number of cases reviewed, it was not clear if all of the child's needs had been fully considered, particularly in cases where communication and cognitive understanding were an issue. Health planning is a priority area for development. Plans are not SMART with unclear timescales and vague accountabilities (recommendation 4.1). Foster carers are not routinely sent copies of the assessments (recommendation 4.4).

4.4 Most health reviews are episodic. They are not informed by the previous review, although these are routinely sent to the assessor to inform the current assessment. Where other services such as CAMHS or SALT are involved with the child, they are not contributing progress information to the health review. We saw a general lack of communication between health services and the looked-after children's health team. This risks the young person's needs not being met in the most appropriate way. This also prevents the looked-after children's health team having sufficient oversight of the involvement of other health professionals (recommendation 4.3).

4.5 The introduction of the new heath assessment template is positive. It has the potential to improve the quality of assessments, reflect the child's development from one assessment to the next and give greater prominence to the voice of the child. The integration of the CRAFFT drug & alcohol screening tool into the template is also a good development. Positively, looked-after children are being encouraged to access A-DASH help and treatment, with double the level of engagement compared to the national average. However, the template lacks sufficient attention on effective SMART health planning and it is too recent an introduction to see its impact (recommendation 4.1)

4.6 Quality assurance of initial and review health assessments is not robust. Whilst monitoring and review of paperwork is undertaken by the designated doctor and we saw evidence of challenges to quality or requests for further information, this is having limited impact as the assessing practitioners do not routinely act on advice or respond to the requests that are made (recommendation 4.2).

4.7 Looked-after children's nurses work closely with residential homes for young people. They visit regularly to discuss general health needs and provide additional support to individual young people as required:

> ***Case sample 13:*** *In the case of one young person in residential care requiring major surgery, effective liaison between the looked-after child nurse, residential home and hospital facilitated a good outcome for the looked-after child: in–patient care was extended while a health needs plan was put in place to ensure a seamless transition back into the community thus optimising the young person's recovery.*

4.8 Health histories and records of immunisations are not routinely provided to care leavers and although we were told that some care leavers are now receiving personalised letters, there is significantly more to do to ensure care leavers are being well served. None of the care leavers we met had received health histories or letters (recommendation 4.5).

> *Care leavers told us;*
>
> *"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"*
>
> *"I nearly lost a job opportunity because I had to prove I'd had immunisations but I didn't know and it took so long to find out. I was told all different people to ring. No one communicates".*
>
> *We agree with these young people that the looked-after children health service is not sufficiently equipping them when they leave care.*

Management

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

5.1 Leadership and management

5.1.1 Partnership working is good. The CCGs, local authority and providers are working co-operatively to respond to the changed requirements in *Working Together 2013* with action planning in train to achieve compliance. The area team has in place a memo of understanding with both CCGs setting out a robust accountability framework for the designated professionals. The area team has a clear vision about how it wants to develop the services for which it has responsibility and is working well with the designated nurse, facilitated by co-location.

5.1.2 Health is well represented on the LSCB and sub-groups. The reconfiguration of the LSCB and the health community gives opportunity for partner agencies to address and respond to the increasing numbers of presentations of certain issues relating to safeguarding. The Hertfordshire & South Midlands NHS England Area Team (AT) Director sits on the HSCB and Health & Wellbeing Board. Strategic managers in the NHS AT, county council, CCG and providers who are members of the HSCB meet for an hour prior to each HSCB board to update each other on developments. This forum has been used very positively to resolve a number of challenges facing the partnership. These include significantly increased numbers of young people who are self-harming and a small but growing number of presentations of female genital mutilation to maternity services.

5.1.3 The CCGs have responded well to the changed requirements in Working Together 2013. Training needs for HCT staff now required to attend court proceedings and strategy meetings are being identified. Providers have been asked to produce action plans to address the new requirements.

5.1.4 The draft strategy for safeguarding and looked-after children is straight forward and sensible with appropriate priorities and measurable objectives to facilitate progress tracking. This strategy has the potential to act as an effective framework for the continuous improvement of health's safeguarding and looked-after child arrangements. Health providers identify strong leadership from the designated nurse who is also supportive and accessible.

5.1.5 Movement towards the establishment of a greater commonality of practice across midwifery services throughout the county has been initiated but currently there remain significant historic disparities between the services operated by the two provider trusts. East &North Herts uses a data base which has stronger features than that used by WHHT; this is to be visited by staff from WHHT as part of the research to inform the potential replacement of the data base at Watford General. There are different paperwork systems across the services, leading to potential complexities if families move between services. There are also different liaison meeting arrangements with children's social care, monthly for East & North Herts with daily contact with children's social care by the named midwife and daily for WHHT (recommendation 10.1).

5.1.6 Skilled and highly experienced paediatric liaison staff and named nurses are in place at the acute hospitals and oversee practice at the urgent care centre. They diligently oversee safeguarding risk assessment practice through systems that are either a combination of electronic and paper recording or, as at Watford, entirely a paper based system. Although their skills and the processes they have established and monitor do mitigate risks, a common IT system across acute emergency services would enable more effective checks and identification of risks (recommendation 10.1). Read only access to the council information system is available to the safeguarding team at West Hertfordshire Hospitals NHS Trust facilitating their access to information which can usefully inform risk assessment.

5.2 Governance

5.2.1 The HSCB provides effective scrutiny of health partners' safeguarding activity, undertaking twice yearly multi-agency audits. Providers' performance on range of child safeguarding issues is well governed by the East & North Herts CCG Quality and Patient Experience Board on behalf of the two CCGs. For example, performance of 2.5 year checks by health visitors is being monitored closely by the board. In September performance was 91.3% and in October 95.8%. The development of the safeguarding dashboard represents a significant strengthening of safeguarding governance arrangements and through monitoring of trends, incidence and safeguarding children activity across the health economy, should usefully inform the commissioning of services. All health trusts operating in the county are required to complete this on a quarterly basis. As this is a new initiative, the dashboard is still in development and will be revised as it is developed. The first year will be used as a benchmark to inform safeguarding activity. It is anticipated that part of this development will include further criteria so that RAG rating can be applied to each dashboard.

5.2.2 Positive work is being undertaken to improve GP participation in child protection case conferences and safeguarding arrangements generally: This includes the development of a report pro-forma by GPs, Herts County Council and the designated nurse. This should improve GP contributions to section 47 enquiries and child protection case conferences. The group model of named GPs to provide leadership and drive improvement across a large and diverse local authority is innovative, with individual named GPs demonstrating leadership and commitment to the role. However, one area remains uncovered and the current uncertainties about their future role have affected the group's ability to formulate a countywide agenda (recommendation 2.1).

5.2.3 East & North Herts CCG is taking positive action to improve Hertfordshire's performance in delivering healthcare to looked-after children: assuming the co-ordination and chair of the joint contract monitoring group and establishing the multi-agency strategic group to oversee the health of looked-after children. Additional resource has been invested by the council to strengthen administrative support to the team and this has proved beneficial. Performance reporting arrangements through the designated nurse and the 'Children Living away from Home' sub-group of the Health and Wellbeing Board are in place. Moving the looked-after children's health team to be part of the community health trust's safeguarding structure has giving clarity of focus, stronger operational support and more rigorous accountability to the team's work. A 0.5 WTE looked-after child nurse has been recruited to the CCG safeguarding team and was about to take up post at the time of this review. The portfolio for this new role is being developed to contribute to the stronger arrangements for looked-after children being developed.

5.2.4 Early indications are that these actions are improving performance, although this is coming from a very low base and is a priority area for development to ensure sustained improved performance. In recognition that the service requires significant strengthening, plans were in place prior to our review to commission a comprehensive review of the looked after children service.

5.2.5 An appropriate range of performance indicators and data collection has been agreed between the CCG and county council commissioners and the provider as part of the 2013/14 service specification. There is not yet a full understanding of the profile of the looked-after children population or specific cohorts within it such as young asylum seekers, looked after young people who are parents, young people returning to the county from out of county placements or looked-after children placed in Hertfordshire by other authorities. Understanding these cohorts and their impact on local health services as well as on the looked-after child health team will be important for future commissioning decisions. Without a full picture of the looked-after child population and its movements, the service and commissioners cannot be confident that the needs of looked-after child are being fully met (recommendation 1.1).

5.2.6 Health agencies demonstrate learning from serious case reviews and take positive action to ensure that improved practice is sustained: An example being that it is established practice for all children who present at the urgent care centre with safeguarding concerns to be sent via ambulance to Watford General Hospital to be seen by a paediatric registrar.

5.2.7 In HPFT, safeguarding governance arrangements are in place but it is not clear how effectively some aspects of practice in adult mental health and CAMHs are being monitored and addressed. This includes care planning, recording practice and ensuring that all staff are fully equipped to undertake their child safeguarding responsibilities effectively. Some recording practice was of unacceptably poor quality; was not an accurate reflection of the practitioner's work with the child and showing little or no analysis of the impact of the work being undertaken or of the safeguarding risks presented by the case. Some practitioners did not appear to understand the purpose of case recording and we saw no evidence that managers ever scrutinised case recording or used the case record to review case work in supervision, although supervision records were not reviewed by inspectors. Robust managerial oversight and the provision of appropriate levels of safeguarding training for managers and practitioners is particularly important given that most frontline staff across the trust have significant involvement with children in the course of their work (recommendation 9.3). Managers in the service felt that some early difficulties with the new electronic patient record (EPR) has affected recording quality and assure us that regular audits of practice are undertaken internally and as part of the HSCB APAG sub-group. Learning is shared with the SBU's through the safeguarding strategy group and practice governance. Further work is being undertaken by the trust to look at effective methods of quality assuring patient records more broadly of which safeguarding is a component part.

5.2.8 Positively, the CAMHS service is currently moving from an 18 week referral to treatment timescale, to 28 days for the first booked appointment. Over 80% of new referrals in the South of the county already meet this timescale.

5.2.9 We saw examples of poor recording leading to the potential for misunderstandings and actions being missed across a number of services and in one case, following the review, managers took prompt remedial action. The general quality of case recording across services is an area for development (recommendation 7.1).

5.2.10 Information sharing difficulties are further compounded by limited progress in extending IT compatibility and some services having stand-alone systems which are unable even to flag safeguarding or child protection concerns. Where there are interface limitations, current systems and arrangements to check risks are not fully effective (recommendation 7.2).

5.2.11 The A-DASH service monitors performance and outcomes effectively demonstrating the services impact on helping young people to access treatment and achieve their self-set objectives. A recent performance report shows that for cannabis use, the service works with young people who present higher levels of risk but achieve better outcomes in shorter periods of intervention than the national average.

5.3 Training and Supervision

5.3.1 The CCGs have set providers a threshold of 95% for safeguarding training at the required competency level. All providers are currently challenged in achieving safeguarding training compliance against the expectation rate. The CCG is monitoring performance closely by means of the new dashboard completed quarterly by all Herts NHS trusts. ‘Light bite’ training slots are an effective way of briefing and updating health staff across services and disciplines on new health and safeguarding developments and staff who attend these told us they find them valuable.

At Watford General Hospital, a good induction for new staff is in place in the emergency department; all new paediatric nurses spend two full weeks with the safeguarding nurses. Newly qualified staff also undertake a paediatric rotation so that they get a wide experience of children’s nursing.

5.3.2 Reception staff at the Urgent Care Centre, Watford General Hospital and Lister Hospital paediatric A&E departments are confident in how to raise any safeguarding concerns observed in waiting areas with clinical staff and we heard a number of examples of when this has happened. Never the less, we felt that the role of reception staff in services with a high volume of children may require a higher level of safeguarding competency training to ensure this cohort of staff are fully equipped to fulfil their risk assessment role (recommendation 10.2).

5.3.3 Similarly, most HCT CASH staff have undertaken safeguarding training broadly in line with the Trust’s policy but more focused training on specific topics would benefit health care assistants. We were not assured that staff had the necessary understanding and knowledge base given the complexity of issues they find and high number of specialist young peoples’ clinics operating in the county. Trust policy states that half a day or two ‘light bites’ LSCB training will also be undertaken covering safeguarding in partnership with other agencies where staff work predominantly with children (recommendation 8.3).

5.3.4 As a result of this review identifying examples of sub-optimal safeguarding and recording practice in adult mental health, a number of remedial actions were taken by HPFT managers and senior social workers with individual practitioners. In addition, the Head of Social Work & Safeguarding is arranging for the Trusts named nurse to deliver awareness sessions and provide a briefing to staff on their role at case conferences. Currently, frontline adult mental health practitioners receive safeguarding training in line with intercollegiate guidance. Given that practitioners come into contact with children in much of their day-to-day work; working with parents, grandparents and adults who have children in their lives, we were not assured by our findings that all frontline staff were properly equipped to discharge their safeguarding responsibilities. The complexity and deficits identified in the cases we reviewed supports the need for a review of the competency based safeguarding training strategy to ensure that staff have the appropriate skillset and level of understanding (recommendation 9.2).

5.3.5 Robust supervision arrangements are in place for health visitors with additional supervision and support being put in place for the cohort of newly qualified practitioners in the service. Records of supervision discussions about specific cases are clearly reflected in the case record. This was not evident in adult mental health and CAMHS however, where case recording did not evidence discussions of individual cases at supervision (recommendation 9.3). Overall, across services we saw no evidence of managerial oversight of record keeping (recommendation 7.1)

5.3.6 At Watford General Hospital, safeguarding supervision arrangements are in place for key midwifery leads and safeguarding staff. Although overall the performance of East and North Herts Hospital Trust on staff supervision is good, supervision arrangements for midwifery services are significantly underdeveloped although practitioners have good access to ad hoc advice and guidance and do receive an annual appraisal. This is not sufficient to ensure staff are fully supported and equipped in line with statutory guidance. Trust managers are aware that this is a priority area for development for the newly appointed named midwife to address and have accordingly recruited a suitably skilled and experienced practitioner to take this forward (recommendation 6.1).

Recommendations

1. NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG should:

1.1 Develop comprehensive data on the profile of the looked after population to ensure that there is a full identification of needs and how these are to be met.

1.2 Ensure that a clear pathway for referrals of young people to A-DASH is in place across all services and that it is used effectively to ensure young people receive the support they need promptly.

1.3 Work in partnership with health agencies and social care to ensure that psychosocial and other liaison meetings are effective in ensuring the protection of vulnerable children.

2. Hertfordshire and South Midlands NHS England Area Team, NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG should:

2.1 Ensure that the named GP role is effectively discharged county wide.

2.2 Ensure that GPs understand their roles and responsibilities in safeguarding children and prompt information sharing and that these are discharged effectively and to a consistent standard.

3. NHS East and North Hertfordshire CCG, Hertfordshire County Council and Hertfordshire Community NHS Trust should:

3.1 Review interfaces of the looked-after children's health team and children's social care to ensure children and their carers receive quality services including the provision of information about children's health care needs.

4. NHS East and North Hertfordshire CCG, NHS Herts Valleys CCG, Hertfordshire County Council, East & North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust should:

4.1 Ensure that the new health assessment template is effective in the development of health care plans that are SMART, setting out clear and measurable health objectives for the child and identifying those accountable for the delivery of outcomes within defined timescales.

4.2 Ensure that children and young people who are looked after benefit from quality, timely initial and review health assessments subject to effective quality assurance arrangements.

4.3 Implement and monitor arrangements to assure effective communication between the looked-after children's health team and other health professionals.

4.4 Work with children's social care to ensure that foster carers are routinely sent copies of children's health care plans.

4.5 Ensure that care leavers are properly equipped with health histories, age appropriate information and contact details should they need to re-engage with the looked-after children's health team.

4.6 Ensure that where CIN and other multi-agency plans setting out the roles of health practitioners in supporting or protecting the child or young person are scanned into service client record systems, these are easily accessible to practitioners.

4.7 Ensure good provision of information and advice to Eastern European and other minority ethnic families on accessing children's community services.

4.8 Ensure that the Healthy Child programme is fully available to all.

5 NHS Herts Valleys CCG and West Hertfordshire Hospitals NHS Trust should:

5.1 Review the service and environment in the post natal ward to ensure it is fit for purpose and appropriately staffed.

5.2 Ensure that patient feedback is regularly evaluated and used to inform service delivery and planning.

6 NHS East and North Hertfordshire CCG, and East & North Hertfordshire NHS Trust should:

6.1 Ensure that all practitioners whose day-to-day work requires a high level of understanding and competence in children and young people' safeguarding and child protection receive regular, formal, planned safeguarding supervision in line with statutory guidance.

6.2 Ensure that adult A&E reflects a robust *Think Family* approach in identifying and responding to risks to children which may result from the presentation of the adult for treatment, including identifying other children present in the adult's household.

7 NHS East and North Hertfordshire CCG, NHS Herts Valleys CCG, Hertfordshire County Council, Hertfordshire and South Midlands NHS England Area Team, East & North Hertfordshire NHS Trust, Hertfordshire Partnership University NHS FT, West Hertfordshire Hospitals NHS Trust and Hertfordshire Community NHS Trust should:

7.1 Ensure that recording practice is of a satisfactory standard, accurately reflects operational practice and is subject to effective managerial oversight.

7.2 Review the provision of information technology systems and manual arrangements to ensure that safeguarding risks in relation to vulnerable children are identified and shared appropriately and promptly.

7.3 Ensure that all health practitioners are clear about the appropriate use of information sharing forms, when to use these and when to make child protection referrals to children's social care.

7.4 Ensure that practitioner referrals to children’s social care clearly articulate the risks to the child or young person in order to facilitate effective decision making in relation to safeguarding the child.

7.5 Ensure that full details about children and young people, including ethnicity, culture and language and the relationships of accompanying adults, are recorded when they present to individual health services.

7.6 Ensure there is effective direct liaison and information sharing between health services in order to protect vulnerable children effectively.

8 Hertfordshire Community NHS Trust with Hertfordshire County Council should:

8.1 Ensure that service arrangements are reviewed and operational practice is aligned with statutory guidance and fully reflective of good practice.

8.2 Ensure that the CASH service recording systems are robust and effective in identifying where liaison regarding safeguarding risks to individual young has taken place people with other agencies.

8.3 Ensure that training given to CASH staff is at the appropriate level and fully equips staff to recognise and address the complexity of safeguarding risks with which they routinely work.

8.4 Undertake regular audits of safeguarding referrals from CASH to children's social care to monitor progress, identify trends or multiple risk indicators which may encompass a cohort of young people and assure continually improving quality.

8.5 Ensure that CASH offer preventative and early help outreach services and have sufficient capacity for targeted work in community areas of higher need.

8.6 Ensure that CASH services operate appropriate safeguards and information sharing and recording protocols to enable effective checks to be made to identify where young people are vulnerable and that vulnerable young people can be flagged across systems county wide to ensure protective action is taken.

9 NHS East and North Hertfordshire CCG, NHS Herts Valleys CCG with Hertfordshire County Council and Hertfordshire Partnership University NHS FT should:

9.1 Ensure that the needs of young people are fully reflected in CAMHS assessments and that young people have an opportunity to be seen alone when they are competent to choose.

9.2 Ensure that practitioners receive safeguarding training commensurate with their roles and that they are properly equipped to work effectively with the complexity of safeguarding issues in their day-to-day practice.

9.3 Ensure that management oversight and supervision arrangements in adult mental health services and CAMHS are robust in ensuring practice is compliant with national guidance and demonstrates continuous improvement.

10 NHS East and North Hertfordshire CCG and NHS Herts Valleys CCG in partnership with Hertfordshire County Council, Hertfordshire Partnership University NHS Foundations Trust and Hertfordshire Community NHS Trust, West Hertfordshire Hospitals NHS Trust and East & North Hertfordshire NHS Trust should:

10.1 Ensure that, wherever possible, commonality of practice and liaison arrangements are established with children's social care and across service provision in order to reduce inequity and ensure effective safeguarding practice.

10.2 Ensure that all staff, including non-clinical staff, receive safeguarding training commensurate with their roles and that they are properly equipped to work effectively in identifying safeguarding issues in their day-to-day work.

Next Steps

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

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