

# **Review of Health Services for Children Looked After and Safeguarding in Swindon**

# Looked After Children and Safeguarding

## The role of health services in Swindon

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<b>Provider services included:</b>	Great Western Hospital NHS Foundation Trust Oxford Health NHS Foundation Trust Avon and Wiltshire Partnership Trust SEQOL CRI, Crime Reduction Initiatives – adult substance misuse Uturn (Swindon Borough Council) – young people’s substance misuse Swindon Borough Council
<b>CCGs included:</b>	Swindon Clinical Commissioning Group
<b>NHS England area:</b>	South
<b>CQC region:</b>	South (Central)
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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 Swindon. 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 Swindon, 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 2013.

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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 78 children and young people.

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## Context of the review

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The resident population of Swindon Borough Council (SBC) was estimated at 201,800 people in 2010 with 24.5% of the population being under the age of twenty. About 14,000 people were aged under five years (6.9% of the total), and 37,200 under fifteen years (18.4%). In 2009 a total of 14.3% of the borough's resident population belonged to black and ethnic minority (BME) communities compared to 17.2% for England as a whole. Nineteen percent of school children are from a black or minority ethnic group. A 2010 schools survey found that 11% of Swindon school pupils have English as a second language (up from 7% in 2010), with a total of 104 languages being spoken. The level of child poverty is better than the England average with 17.8% of children aged less than 16 years living in poverty. The rate of family homelessness is better than the England average.

The health and well-being of children in Swindon is generally similar to the England average. Infant and child mortality rates are similar to the England average. Children in Swindon have average levels of obesity. 9.9% of children aged 4-5 years and 18.9% of children aged 10-11 years are classified as obese. 53.1% of children participate in at least three hours of sport a week which is worse than the England average.

In 2010/11, there were 4,608 A&E attendances by children aged 4 years and under. This gives a rate which is lower than the England average. In comparison with the 2004-07 periods, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose has decreased in the 2008-11 period.

Recently published child health profiles suggested that Swindon has a very high hospital admission rate for child mental health problems. There are concerns about the recording of respite admissions, however, and the fact that these have affected the overall admission rate. Swindon has also been found to have a very high hospital admission rate for self-harm. The most recent available data indicate that there are 243.7 admissions for self-harm per 100,000 Swindon residents aged 0-17 in 2010/11. This is significantly higher than the national average of 158.8.

Currently 28% of all violent crime can be attributed to domestic violence and this continues to be a significant issue in Swindon. There were 2,474 incidents of domestic violence reported to the police in Swindon in 2011/12, with approximately 3,000 children living in those households. It is recognised nationally that only around 20% of domestic violence incidents are reported to the police, which would suggest that there are potentially nearer 12,000 cases in Swindon. 350 children who were part of 230 families were referred to the MARAC panel in the 12 months to January 2013.

In March 2013, 147 children were on a child protection plan, up from 116 at the end of March 2012. Initial Child Protection Conferences increased from 149 to 186 between 2011/12 and 2012/13. Needs profile work undertaken by Swindon Borough Council shows that higher proportions of children on a child protection plan are from areas with high levels of deprivation.

There were 250 children in care in March 2013 with 57 children in care in commissioned placements. This has remained stable compared with the previous year where the rate of children in care was 57.1 (253 children). The main group where there has been an increase of children coming into care has been for young females age 16+ from a white British background. There has also been a significant increase in the number of 5-9 year olds coming into care on interim care orders. Swindon has the 3rd highest rate per 10,000 population of children in care compared with its statistical neighbour. It is however below the national average by a rate of 6 per 10,000 population.

Swindon has retained its Children's Trust which oversees the multiagency development of early support to children and families. The Children's Trust Board has developed a Children and Young People's Early Support Strategy 2013-2016. In July 2013, 10 young people were being monitored by the Child Exploitation Risk panel.

Commissioning and planning of most health services for children are carried out by the Swindon Clinical Commissioning Group (CCG) in collaboration with Swindon Borough Council through a section 75 agreement.

The children's and adults joint commissioning board monitors the financial arrangements and performance of the NHS Section 75 Agreements. A joint commissioning plan is in place so that both partners have clear joint priorities to improve outcomes for children and young people. The NHS Section 75 Children Agreement has a value of £25m and includes all local authority children's services, community based health services, CAMHS, community paediatric services, placements and services for disabled children. Four integrated locality teams and an integrated service for disabled children and young people deliver universal and targeted services.

Commissioning arrangements for looked-after children's health are the responsibility of the CCG and Swindon Borough Council and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by Swindon Borough Council and Great Western Hospital NHS Foundation Trust (GWHNHSFT).

Acute hospital services are provided by Great Western Hospitals NHS Foundation Trust which includes a new Children's Emergency Department opened in December 2013, delivery suite and maternity services.

School nurse services are commissioned by the NHS Local Area Team in collaboration with Public Health in Swindon Borough Council and provided by Swindon Borough Council.

Contraception and sexual health services (CASH) are commissioned by Swindon Borough Council and provided by Great Western Hospitals NHS Foundation Trust.

Child substance misuse services are commissioned by Swindon Borough Council and provided by Swindon Borough Council in a service called Uturn.

Adult substance misuse services are commissioned by Swindon Borough Council and provided by Crime Reduction Initiatives (CRI)

Child and Adolescent Mental Health Services (CAMHS) are provided by Oxford Health NHS Foundation Trust. One of their two in-patient units, Marlborough House, is in Swindon, offering a setting where young people can be assessed and treated for psychiatric disorders. They provide assessment, treatment and support for young people up to 18 years old

Adult mental health services are provided by Avon and Wiltshire Partnership Trust.

There have been no publications of Serious Case Reviews (SCR) in regards to children in the Swindon area in the previous 12 months.

The last inspection of health services for Swindon's children took place in June 2009 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The findings concluded that the overall effectiveness of the safeguarding services in Swindon was "good". Overall effectiveness of services for looked after children and young people in Swindon was judged to be "good". As this was an early safeguarding and looked after children's inspection (SLAC), there was no separate safeguarding judgement for health's contribution to safeguarding and this is why we undertook this review. Recommendations from that inspection are not covered in this review although references to developments since the joint inspection are included.

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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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### **Parents told us about the benefits of the early help they have been offered;**

*"The health visitor helped me recognise my problems. She was fantastic. We really clicked. She got me to the doctor and I got help."*

*"I can talk to the health visitor. She is like a friend. She put me in touch with LIFT (a voluntary sector provider). I'm glad I went and I will take up the support offered."*

*"The two weekly visits from the health visitor serve me well. I look forward to her visit."*

*"I've been offered a 20 week course with NSPCC to help me with my self-esteem. The health visitor explained it to me and I think it will help."*

### **A parent with a child on a protection plan told us;**

*"I can sing the health visitor's praises. She focuses not only on the child but also on me. She is brilliant and praises me which people don't usually do. She reassures me about feeding problems and gives me alternatives to try."*

*“The health visitor will speak up at conferences if she doesn’t agree and I admire her for that.”*

### **Foster carers told us;**

*“The looked-after children’s nurse has been really helpful. She puts my mind at rest and is easy to get hold of.”*

*“The looked-after children’s nurse will go away and get the answer and come back to us and will go to the birth mother to take any anxieties away.”*

*“It is easy to get to the centre and I always pop in for a chat with the looked-after children’s nurse. She is always available and is supportive.”*

*“All the health professionals have been brilliant, the health visitors and the dieticians. The paediatrician has maintained him on her caseload too. He is a success story and now is very rarely at the GPs”.*

*“The looked-after children’s nurse comes to the foster carers’ support group when topics are relevant.”*

*“The foster carers’ group heard that we can’t get help from CAMHS because it’s not a stable placement. Not easy to get CAMHS anymore. It used to be.”*

*“We have always found contacting CAMHS easy but we do hear from other foster carers that this can be difficult. For children to access CAMHS support, the GP has to refer.”*

*“We do SDQs (strengths and difficulties questionnaires) and send them to the looked-after children’s nurse. They are quite restrictive and a bit subjective. It’s not always clear what they are for and I think they could be used more creatively.”*

*“Great Western Hospital A&E are quite good at listening to foster carers but other departments, not so good. The doctor in the ENT didn’t want to speak to me and didn’t understand the foster carer role. It got very confused and took a while to sort out the parental responsibility issue.”*

### **We heard about health reviews for looked-after children;**

*“The school nurse does the review. It’s the only time I see her. It’s the same thing every time. I don’t get anything out of it.” – young person*

*“The doctor is very positive with the children. She lets them play with the equipment and they feel empowered.” – foster carer*

*“Reviews by the paediatrician are very brief. This can be sufficient for some but not very in depth for others.” – foster carer*

*“I wouldn’t call it a plan but I do get a letter in the post covering what was discussed.”  
– foster carer*

*“Some joint meetings with the birth parents have been arranged by the paediatrician and these have been well managed.” – foster carer*

### **Care leavers told us;**

*“I wasn’t really listening at my health review. It was just a hassle. Looking back at it now, it makes sense.”*

*“I want a health history so that I will know about my health. I think that’s important.”*

*“Health was covered in a two minute conversation at my looked-after child review. It should have more time.”*

*“A group of young people together in a more relaxed atmosphere would be more helpful to care leavers. Could still have the confidential one to one but do it more as an event. Care leavers and older teens would be more up for that. “*

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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 Many vulnerable children and families in Swindon have access to a good and increasing range of health and social care led early help services which are effective in delivering positive outcomes for children and vulnerable families; examples include the CRI (Crime Reduction Initiatives) parenting group, drop-in sexual health clinics run by school nurses in schools in areas with highest identified need and LIFT, a support service provided in the voluntary sector. Parents and young people accessing these and other services told us they valued them and felt they were benefitting themselves and their family. However in some service areas such as paediatrics, we were told that expansion of early help services is limited by capacity pressures. An example being that the consultant paediatrician we spoke to was unable to establish a clinic dealing with child neglect due to lack of service capacity.

1.2 Midwives are routinely prompted in newly designed paperwork to consider domestic violence as part of the booking in process and this is a positive development. There is good practice in reporting domestic violence to appropriate agencies and open discussions around incidents is encouraged and supported by the community midwifery team, in line with departmental protocols. Safeguarding maternity liaison meetings are effective as a way of sharing information to keep unborn and infants safe. Midwives engage well with health visitors and practitioners in adult substance misuse and mental health services; and pre-birth and discharge planning meetings are well attended by relevant services. This is facilitating effective information sharing, early planning and signposting to lower levels of community services operated by health, social care and third sector providers. We saw and heard about positive outcomes from this approach. Although there is a perinatal mental health pathway which engages the mental health nursing team from AWP, there is no psychiatrist with a special interest in maternity in Swindon which impacts on the service delivered. There is a business plan to develop the perinatal service but it is not clear how this is being progressed (recommendation 1.1).

1.3 Joint working between midwives and health visitors is encouraged for targeted families, with protocols in place for antenatal visits by 32 weeks. In line with the new maternity liaison pathway, liaison and joint working between community midwifery and health visiting to share information and prioritise families who would benefit from an enhanced community support package, is good. Health visitors are responding quickly to potential safeguarding concerns raised through intelligence received by children's social care, by undertaking additional home visits. A robust family nurse partnership (FNP) pathway is in place, offering 100% access to all mothers aged 18 and under.

1.4 The opening hours of the urgent care centre make it easily accessible to families seeking urgent treatment and the provider, SEQOL, employ a proactive approach to finding new ways to meet children's acute health needs. Staff in the service are clear on how to articulate and action their concerns around safeguarding to the appropriate person. The use of automatic notifications to community and primary care services of all presentations of young people aged under 18 years acts as a further safety net and contributes to the reduction of risk, quality assurance and accountability for decision making. Opportunities to observe behaviours and interaction in the waiting room are built into the assessment process and this is good practice. We saw evidence of heightened awareness of reception staff to safeguarding concerns and appropriate reporting and escalation of these to the named nurse. Information was clearly recorded in notes and actioned quickly to inform children's social care. We observed staff taking a proactive approach to liaising with social workers, ensuring that information was shared with the appropriate professionals outside the Swindon area about a young person's risk taking behaviour.

1.5 At Great Western Hospital (GWH), children's emergency department (CED) reception staff understand their safeguarding responsibilities in recognising and reporting any concerns they have about the safety of a child and were able to cite a recent example of when they identified some concerns and notified the senior nurse.

1.6 There is good awareness at GWH of the risks of vulnerable children and young people going missing from a busy emergency department. A protocol is in place to minimise risks of a child going missing when these risks are identified. This includes a recorded description of the young person's appearance and clothing to aid identification by police if they do abscond and we saw a case example of this protocol having been followed.

1.7 When referrals of children attending paediatric services are made to the paediatric liaison health visitor, the health visitor acts as a conduit to expedite notifications into community health service. However, not all necessary referrals to the paediatric liaison health visitor are being made to ensure that this happens and we saw a number of cases where notifications had therefore not been passed to community services. This included one case where a child, subject to a child protection plan, attended CED in September and the health visitor had not received notification of this attendance at the time of this review. Where notifications are received in community health services, the quality of the information these contain about risks and vulnerabilities, is variable. They do not always convey sufficient information for primary care and community health to act upon to ensure the child's needs are met (recommendation 3.7).

1.8 Effective processes are in place to ensure that the acute hospital information system flags medical alerts regarding children who have been made subject to child protection plans, become looked-after children or are living in families where domestic violence has been identified. This supports staff's safeguarding risk assessment in the acute setting. At GWH, we reviewed a number of examples of good identification of safeguarding issues and potential risks to children. We saw some good examples of history taking and risk assessment by ambulance crews and some CED clinicians. As a result of prompt referrals to children's social care, children have been protected. However, safeguarding practice in the ED is not of a consistent, acceptable standard. In one case reviewed, safeguarding issues were not identified when a child on a child protection plan attended CED in late 2013. Whilst the concern had been raised at the ED clinical governance meeting, we saw no evidence that performance issues have been raised subsequently with the relevant clinicians to ensure improved practice. Neither could we see that effective measures have been put in place in the department to ensure that all potential safeguarding issues are identified when children attend for treatment (recommendation 3.6).

1.9 There is good engagement of most health services with the multi-agency risk conferences on domestic violence (MARAC) with routine attendance by domestic violence lead staff from various disciplines such as CED and midwifery. This is facilitating effective information sharing which informs risk assessment of vulnerable children. GPs we met however, had little awareness of MARAC and no direct engagement with MARAC or MAPPA (multi-agency public protection arrangements) or information sharing on domestic violence (recommendation 5.3).

1.10 Great Western Hospital CED operational leads recognise a need for clinicians to ask questions about young people's alcohol consumption and sexual activity more routinely to help identify safeguarding risks. The development of a new protocol between Great Western Hospitals NHS Foundation Trust (GWHNHSFT) and Uturn whereby all young people with identified alcohol issues attending ED will automatically be referred to Uturn to receive a follow-up contact within five days, is positive.

1.11 Uturn are highly flexible in their approaches to engage young people with substance misuse issues with the service and we saw positive outcomes for the young people. Their assessments are comprehensive and information is shared effectively to ensure the young person's rapid access to appropriate services such as the targeted mental health service (TaMHS) for lower levels of emotional difficulties.

1.12 All services visited have robust policies for when young people and children do not attend or are not brought to appointments (DNA) and all health practitioners demonstrate dogged and determined efforts to ensure the continued engagement of both children and adults with services. Services including Uturn and CAMHS will extend their involvement with a young person beyond the usual age range if that is to the benefit of the young person. They will also maintain a young person on their caseload where there is no active involvement but the practitioner is acting in a consultative role to professionals working with the child. This commitment to the wellbeing of often very challenging children is very evident.

1.13 Children and young people attending GWH with mental health issues have good access to CAMHS assessment which is routinely available at weekends. There are positive therapeutic outcomes for children who are engaged with the CAMHS service, particularly for the cohort of young women subject to or at risk of child sexual exploitation. However, we did hear from a number of foster carers and other services that they felt CAMHS had become hard to access and that there are delays in young people being able to access the service. The complex case consultations which have recently been introduced to help move children with complex needs promptly to the appropriate support services are a potentially positive innovation. The frequency of the consultations is currently fortnightly. However, with six looked-after children currently waiting for their consultation, this warrants reconsideration as there is the potential for additional delay to develop, undermining one of the main objectives of the model. It is too early to evaluate the impact of the consultations and the method of evaluation of the pilot has yet to be fully thought through (recommendation 2.2).

1.14 The CRI service for adults misusing substances commendably undertakes home visits for all its service users and prioritises those where there are children in the household under five years old. The service is effective in identifying children with whom the service user has regular contact and the potential risks to their health and well-being. Visits are undertaken jointly with health visitors and other services where any concerns are identified. The service is building positive relationships with other services as part of the developing early help offer and community capacity building. This includes joint clinics with a midwife with special interest in substance misuse and HIV. We were told about an effective team around the child process in a very chaotic family situation where all family members were highly vulnerable to harm. The team around the family was convened promptly and worked cohesively, resulting in clear benefits to both the parents' and children's health and well-being and resulting in a family arrangement that works well for them; the case is now closed to CRI. This was good practice.

1.15 Cases we reviewed in adult mental health showed good identification of children in the household and good consideration of the cultural and language needs of the service user. The service is strengthening its approach to children's risk assessment through the introduction of a new, comprehensive children's assessment framework based on signs of safety but this is not yet established. We saw excellent practice in one case where the adult mental health service, maternity service and the health visitor worked in a prompt, cohesive and creative way to support a highly vulnerable mother and new born baby. However adult mental health practitioner's liaison with other professionals is not always as well secured and we both saw and heard about case examples where community health staff had been unable to liaise effectively with Avon & Wiltshire NHS Partnership Trust (AWP) workers when supporting parents with vulnerable children, despite efforts on their part to engage (recommendations 1.1 and 1.3).

**Case example:** *a new mother developed psychosis shortly after discharge home and was admitted for in-patient psychiatric care. As a result of prompt and innovative multi-disciplinary liaison involving midwifery services and adult mental health, she and her baby were re-admitted to the maternity ward. Registered mental health nurse support was provided to the ward to ensure the mother's mental health needs were met while she was supported to care for the baby.*

*After a few days, a placement was secured for mother and baby at a specialist unit within the region.*

*This highly effective joint work enabled mother and baby to remain together at a crucial stage of the development of the mother and baby relationship.*

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## 2. Children in Need

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2.1 Practitioners across health services tell us that they welcome the introduction of the signs of safety approach which has brought sharper focus to the multi-agency work with troubled families. The common assessment framework (CAF) has been redesigned under the strengthening families programme and feedback from health visitors is that this has brought beneficial outcomes to families and we saw and heard case examples which support this view.

2.2 Midwives make good use of patient of note documentation to handover information to health visitors where children with vulnerabilities are identified. However, midwives identified the lack of routine access to specialist support, such as perinatal mental health support, resulting in the service supporting a number of expectant mothers with lower but worrying levels of mental health needs. Mental health currently do not participate in the maternity liaison meetings where these needs are discussed and midwives are concerned that they are not equipped to meet perinatal mental health needs (recommendation 1.1).

**Case example:** *A care leaver gave birth at GWH. A domestic violence report was logged by the lead safeguarding midwife in line with routine midwifery practice. The community midwife was notified and a follow up discussion took place and was recorded by the midwife as per the service protocol.*

*A clear written handover was sent to the health visitor setting out the identified concerns. The case was discussed at MARAC, support put into place for mother and baby and an alert placed on electronic notes for 12 months.*

2.3 We reviewed some good quality Child in Need (CIN) plans setting out clear expectations of the changes which need to happen in a family and the support which the family can expect from the multi-agency team. The consequence of parental non-compliance with the plan is set out unequivocally as are the measures of progress and positive change. CIN plans are not always being sent to all relevant professionals involved with a child's case however. We reviewed one case in adult mental health where the practitioner did not have the CIN plan making it impossible for them to discharge their role in the plan or contribute effectively to discussions about progress against the plan. There was no evidence that the worker had made efforts to obtain the plan and practitioners need to be more proactive in ensuring they are best equipped to support a parent and child effectively (recommendation 1.3). We also saw a case where the GP involved was alerted to the child's status as CIN only due to the child being a case tracked by this review, as he had not received any other notification or correspondence previously.

2.4 The Family Nurse Partnership (FNP) is well established. Outcomes have been positive with the majority of families on exit, i.e. when the child reaches two years of age, only requiring universal services. Local evaluation of the impact of FNP indicates a reduction in CED attendance, reduction in parental smoking, increased use of contraception with fewer subsequent pregnancies and increased immunisation uptake. There is also emerging evidence of improved child developmental milestones (i.e. language acquisition, cognitive and social emotional skills) compared to a comparison group.

**Case example:** *The Family Nurse Partnership provided support to a young mother in a relationship known to include violence in the past. The work of the FNP in the case included the healthy relationship programme.*

*The FNP worker highlighted safeguarding concerns to the social worker via a detailed email on becoming concerned about parental behaviour. The initial case conference (ICPC) took place within 1 week of this contact and child was placed on a child protection plan.*

*The FNP worker was proactive in contacting children's social care, articulating the risks clearly which facilitated escalation to a child protection plan*

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### 3. Child Protection

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3.1 Most professionals with whom we spoke understand the thresholds for referral to children's social care. A number of practitioners in different services acknowledged however, that they do not always follow up telephone referrals in writing in line with the agreed protocol and in CAMHS they were unable to locate their written referrals. This means that referrals cannot routinely be reviewed by managers to assure quality and makes it difficult for managers across the health and social care interface to properly address issues where the escalation protocol may be invoked (recommendation 2.4). We were told that guidance on how to make a good referral has been developed in the adult mental health service and is available to practitioners, although managers acknowledged that this is not yet used routinely.

3.2 Where the risk of significant harm is articulated clearly in written referrals to children's social care, this is supporting effective decision making and ensuring the child has access to the level of support most likely to protect them. We saw some examples of good practice in this respect; notably in the family nurse partnership where a clearly articulated and effective referral facilitated prompt inception of a child protection plan, with the initial child protection case conference (ICPC) taking place within one week of the referral and another example in SWISH, the contraception and sexual health service. This is, however, an area for development in some services. In the CRI adult substance misuse service the referrals we reviewed did not set out the practitioner's concerns sufficiently clearly although these had been made for valid concerns about the safety of the children (recommendation 4.1). We were unable to review any referrals to children's social care generated by adult mental health practitioners and did not see any child protection cases when we visited the service. Managers assured us that the service prioritises attendance at core group and child protection conferences although we identified a mixed picture of adult mental worker attendance from other services we visited and this warrants further review by AWP managers. We also heard from a parent with a child on a child protection plan that the allocated CRI worker does not always attend the core group (recommendation 4.2).

3.3 Pre-birth protocols are effective and communication around child protection plans for unborn children is robust. Maternity staff are aware of child protection plan details when the mother presents at the delivery suite and act accordingly to notify relevant professionals and engage them in discharge planning.

3.4 Health services are routinely engaged in strategy meetings and we met several practitioners in community health services who had been able to contribute their expert knowledge of a child and family to this key decision making forum. Where practitioners are less experienced in child protection, they are well supported by named nurses or safeguarding leads to participate. Where chronologies are used in case recording such as in the school nurse service, these are effective in directing practitioners to key events in the child's life and identifying the level of engagement of the parent with the service.

3.5 Health visitors have a pragmatic and flexible approach to supporting families where there are complex health issues and children are subject to child protection plans. This includes arranging appointments in a way that meets their needs and ensures consistency in the child having contact with health professionals at regular intervals and reducing the risks of non-attendance.

**Case example:** *Pre-birth concerns were identified and a child protection plan was promptly put into place. An enhanced health visitor package of support was provided to mother and baby, which helped to reduce the level of risk to the child. At a subsequent case conference the child protection plan was stepped down to a CIN plan and support was reduced to universal service.*

*Intelligence received by children's social care about possible substance misuse issues at the home was passed to the health visitor who promptly undertook an additional home visit. Follow-up liaison with the social worker maintained the child on a CIN plan.*

*As a result of further concerns and the key contribution of the health visitor's assessments to the professionals' meetings, the case moved again to ICPC and the child was made subject of a new child protection plan*

3.6 Service users, including those whose children were subject to child protection plans, find the groups offered at CRI useful and welcome the additional support to their parenting capacity being offered by the introduction of a new mother and baby group.

3.7 Overall, GPs are not well engaged with safeguarding and child protection arrangements and this is a priority area for development. Attendance at child protection conferences is rare, even when the GP has identified their own concerns about a child and is aware the child is subject to a child protection plan. In one case we tracked across services, the GP held potentially vital information about the child yet submitted no reports to conferences and had not engaged in direct liaison with any other agency involved with the case (recommendation 5.2).

3.8 Multi-agency work underway to understand and tackle child sexual exploitation (CSE) in Swindon is excellent. The multi-agency risk panel (MARP) operates effectively and there is good information sharing and engagement across most services, the exception being GPs who appear to be disengaged from this work and are not referenced in the MARP's operating protocol. The work by Swindon Integrated Sexual Health (SWISH) in this extremely challenging area is exemplary. The service is making a significant contribution to helping to identify young people at risk of CSE while delivering a supportive and high quality contraception and sexual health (CASH) service with which young people want to engage. School nurses, in joint work with school safeguarding leads, have developed a four week targeted course for young women identified as being at risk of CSE and which uses *My Dangerous Lover* material. Currently there are two of these groups operating with up to seven girls in each group. CAMHS were also delivering high quality support to a number of young people identified as being at high risk of CSE and we reviewed a number of cases where a CAMHS practitioner from the outreach service for children and adolescents (OSCA) team was supporting this cohort of young people very effectively.

**Good Practice Example:** *The community contraception service and acute sexual health service merged in 2011 to become SWISH (Swindon Integrated Sexual Health). The team consists of 3 consultants, outreach nurses, health advisors and health care assistants operating clinics in GWH, two dedicated youth drop in clinics and college clinics weekly so that services are well known and accessible to young people.*

*At drop in, patients must see at least two of the professionals present (usually a doctor/nurse then health advisor worker). This is an effective way of encouraging young people to engage with the service and to ensure as much information as possible is gained at clinic. Young people are then identified for additional outreach nurse follow up if assessed as appropriate through the comprehensive risk assessment tool.*

*SWISH provide training on use of their risk assessment tool to school nurses, youth engagement team, foster carers, Uturn, social workers, school pastoral workers and education support workers in both mainstream and specialist educational provisions. This ensures they have a good understanding of areas considered by SWISH and develop their knowledge of scoring thresholds and areas of concern in sexual health and potential for CSE. The use of the SWISH risk assessment across a range of services promotes assessment consistency.*

*The service is fully engaged with the multi-agency risk panel (MARP), sharing information of young people known to be at risk of CSE as part of the strong Swindon approach to tackling this issue.*

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## 4. Looked after Children

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4.1 Foster carers were very positive about the accessibility of advice and guidance from both the looked-after children's nurse and the designated doctor. They particularly found the clinic environment reassuring with toys for the children to play with and liked the way that the paediatrician let the smaller children play with equipment to lessen their anxieties about being measured and weighed.

4.2 The looked-after children's health team know many of the cohort of looked-after children well and foster carer's we spoke with felt well served by health services generally. Children and foster carers benefit from the continuity of relationships with the designated doctor and looked-after children's nurse who both bring passion and commitment to their roles.

4.3 However we did identify a number of key areas for improvement and overall, we felt the provision of looked-after children's health needed further development and the establishment of an effective agreed quality assurance and performance framework. We saw some comprehensive initial health assessments which included good parental health history and relevant information but overall the quality of initial and many review health assessments was poor. The assessment contained only the most basic information and entries by paediatricians and there was little evidence of the voice or sense of personality of the child. In most cases it was not clear where the child had been given the opportunity to contribute directly as most responses were taken from the foster carer or professional accompanying the young person. Review health assessments by community health staff are of better quality and we saw some good reviews undertaken by school nurses. Effort was made to give voice to the child and the review was more comprehensive as a result.

4.4 We found incomplete information contained in some children's records and administrative systems in the looked-after children's health team are not robust. There is little order in the child's record making it difficult to track the child's journey and for the service to ensure that processes happen in a timely way (recommendation 3.3). In a number of cases we saw the agreed review health assessment (RHA) process being replaced with a paediatrician's letter as a record of the appointment. The level of information contained in these was variable, contributing to the episodic nature of RHAs and it was difficult to see the outcomes and evaluation of previous plan targets clearly. There was little evidence of any continuity between assessments or plan. Health plans are not SMART. They are task focused with loose timescales making it difficult to assess progress over time or to ensure prompt follow up on key actions (recommendation 3.2). The looked-after children's nurse does not have access to medical online notes and therefore writes plans from paperwork which is usually in the form of the letter provided by the paediatrician.

**Case example:** *In one case the initial health assessment was completed within timescales however there was very limited information contained within it and many areas of the documentation were crossed out.*

*An adoption medical report was used as a review health assessment. The health plan did not show follow up or evaluation of targets from previous assessment.*

4.5 Capacity pressures on the looked-after children's nurse last summer resulted in a significant backlog of health plans waiting to be developed following health assessments, in one case there was a gap of five months between the young person's health review and the production of the health plan. Currently, health plans are being produced within a month of the assessment which requires further strengthening. Where there are these delays in health planning, there is a risk that children's health needs are not being met (recommendation 3.1).

4.6 Older teenagers are being offered health reviews but are also sent a 16+ questionnaire which was developed with the input of young people some years ago. While this is effective in encouraging the young person to engage with exploring their health and wellbeing and gives them a voice, this questionnaire is not a substitute for a health review undertaken by a health professional. The service and commissioners should be cautious about converting information from these questionnaires and third party information from other professionals onto RHA documentation and counting this as a review. It was not sufficiently clear from the example we saw, that this was third party information gathered from other professionals rather than a face-to-face-review involving the young person themselves. (recommendation 3.1)

4.7 We saw no examples of GPs and other specialist services such as CAMHS contributing progress reports or other intelligence which could usefully inform the child's annual health review. CAMHS practitioners told us that they do not routinely send progress reports to the looked-after children health nurse. Without contributions from all health services regularly seeing the child and particularly those services providing specialist therapeutic intervention, health assessments cannot be considered comprehensive.

4.8 Health support provided to care leavers is being developed but capacity pressures within the looked-after children's health team has limited this area of work. A health passport has been co-produced with young people some time ago but has not yet been embedded in the service. Care leavers we spoke to did not recall being given any useful health history, age appropriate information or health passport as they left care and felt that they should have had more support at such an important time in their life. This remains an area for development. (recommendation 3.4)

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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 Partnership working is well established and very positive. Health providers are well engaged with the LSCB and the work of the Children's Trust and Health and Wellbeing Board. Relationships and arrangements with NHS England area team are developing well although it is early days. The strong commitment to joint commissioning between the CCG and the local council has facilitated the development of improved and targeted commissioning arrangements for specific services such as drugs and alcohol. The recently commissioned CRI (Crime Reduction Initiative) service is delivering good outcomes for adults dealing with substance misuse and as a result, also for children. The joint commissioners have identified governance and quality assurance as an area for development and we concur with that assessment.

5.1.2 Maintaining the Children's Trust to focus on the development and provision of early help services has facilitated beneficial developments in the early help offer. We heard positive examples across services of the increasing range of support available and from parents whose families were benefitting from a number of these services. An example of measurable outcome from this strategy being a maintained reduction in numbers of under 5s becoming looked-after children due to effective early help support.

5.1.3 The continuity of some senior personnel from the primary care trust (PCT) into the CCG has facilitated a smooth transition building on previously established relationships. The shared understanding of the history of local services has been used to good effect in moving service development and delivery forward in the first year of the new health landscape. The CCG has a clear understanding of its role in monitoring the quality of service providers safeguarding activity and is developing its approach to discharging this role, although this is an acknowledged area for development.

5.1.4 Named professionals and in particular, named nurses across services are providing strong safeguarding leadership to frontline staff which has gone some way to mitigate the lack of a substantive designated nurse over a protracted period. They are well known and staff tell us that they are accessible, giving prompt and sound advice. GWHNHSFT has acknowledged demand and capacity issues within the midwifery service and recently increased the provision of the named midwife post. The impact of this increase in allocated time is yet to be fully identified although midwives told us that they appreciate the increased access they have to the named nurse's strong leadership and guidance. The absence of a substantive designated safeguarding nurse and named GP roles and resultant lack of strategic and targeted leadership is likely to have contributed to some of the patchiness of safeguarding practice we have seen in some areas. In particular the absence of safeguarding leadership brought to GPs by the role of named GP has been a significant contributing factor to the current limited contribution of GPs to children's safeguarding and lack of GP engagement in wider safeguarding arrangements (recommendation 5.1). GPs with whom we spoke reported no real engagement with the NHS England area team to date although the area team has a clear vision about how it will develop its role and has established an area safeguarding forum.

5.1.5 The presence of the named nurse in children's social care's referral and assessment team is facilitating cohesive working between practitioners from different disciplines and is beneficial in supporting frontline practitioners undertaking core assessment to consider health issues.

5.1.6 Changes made to the health visitor service delivery model in response to frontline staff feedback has had a positive impact on strengthening families' engagement with the service and is enabling practitioners to build good relationships with families and children.

5.1.7 We have seen health services which are open to learning and this is a strength. Frontline practitioners in GWHNHSFT cited a number of examples of practice improvements which had been introduced as a result of past SCRs and are now established. Partners have used the Social Care Institute for Excellence (SCIE) review model to good effect, citing examples of the introduction of new toolkits and pocket guides which support good practice which have been developed.

5.1.8 The Swindon partners have been prompt in recognising the need to improve the local response to young people at risk of sexual exploitation and in 2012, the LSCB established the protocol and task group. This group has developed the multi-agency risk management operating protocol which outlines the roles and responsibilities for those working with young people who are deemed to be at high risk. In line with the protocol, the multi-agency risk panel (MARP) has been established and is well attended by children's social care, sexual health (SWISH), police, youth offending team, locality teams, and CAMHS. It links well with the LSCB sexual exploitation and runaways sub-group. However with the lack of a named GP role locally, the link with primary care is not strongly developed (recommendation 5.3). The panel has introduced the very useful Swindon vulnerability checklist to assess the young person's level of risk and cases deemed to be high or very high risk are discussed at the panel. Where young people are close to 18 years old, the panel considers transition plans and pathways into adult safeguarding or other appropriate risk management forums such as MAPPA and MARAC to ensure ongoing protection. Key to this panel's success is the Swindon multi-agency information sharing protocol introduced in 2010. This facilitates the effective sharing of information about young people identified as being at risk by signatory agencies including the police, children's social care and the contraception and sexual health service, SWISH. This effectively ensures that no single agency is holding on to information about risks to children and young people inappropriately and is a commendable agreement.

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## 5.2 Governance

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5.2.1 Health and social care partners have developed an audit framework for health and wellbeing practitioner groups. The frameworks are designed to ensure regular scrutiny and oversight of casework by all levels of management. The framework includes such elements as case file audit, practice observation, staff and manager focus groups, regular team 'health checks', a 'secret shopper' exercise and feedback from children and families aimed at ensuring an analysis of the quality of work and the identification of areas of improvement.

5.2.2 Governance of the provision of health for looked-after children is under developed. Regular performance monitoring reports to ensure the timeliness of initial and review health assessments are not being requested by commissioners and quality assurance processes currently in place are not robust. There are no regular performance monitoring and review meetings. There are some internal auditing arrangements which the looked-after child nurse has developed but these are not driving up the quality of health assessments or health plans.

5.2.3 The looked-after children's nurse sits on the corporate parenting board and this is positive and consistent with the strong partnership arrangements locally. The nurse also attends regional networks where good practice is discussed and ideas shared. Peer review has been discussed regionally but has not yet been progressed. The nurse holds a role which combines elements of the designated role while functioning as the operational looked-after children's nurse. In light of the change in commissioning landscape there is a potential conflict of the designated professional's governance role vs the focus of the looked-after child nurse role being that of provider (recommendation 3.5).

5.2.4 There are robust working relationships between acute health services at GWH paediatric emergency and ward staff and staff at the UCC. UCC staff have had ready access to ad hoc supervision and liaison with colleagues in GWH paediatrics in number of the cases we have seen. The automatic electronic flagging system for children on child protection plans was seen to be working consistently; however, there are issues about the reliance on the automated GWHNHSFT ED attendance notification system. GPs and other community practitioners tell us that these notifications do not help them respond to any vulnerabilities or safeguarding issues. This system is less effective than that which is provided by the UCC, which is highly regarded as useful, particularly by GP's.

5.2.5 At GWH, the ED clinical lead role is prioritising the development of effective safeguarding practice across adult and CED. Safeguarding processes are in place, however practice monitoring is underdeveloped. The provision of a paediatric liaison health visitor, employed by Swindon Borough Council, at GWH is good practice although the role has not been used to best effect. There is no process in place in the GWHNHSFT ED by which all under 18 presentations are reviewed to ensure all safeguarding issues have been identified prior to discharge. The potential safeguarding quality assurance role of the paediatric liaison health visitor has not been fully explored and this is a missed opportunity as the role is being retired at the end of March 2014 (recommendation 3.6).

5.2.6 Opportunities to give positive feedback to consolidate clinicians' good safeguarding practice are also being lost and sub-optimal practice is not addressed promptly. Given some of the cases reviewed where safeguarding risks have not been identified and acted upon, GWHNHSFT board and operational managers and commissioners cannot be assured that safeguarding risk assessment in ED is fully effective and that all children are safe when discharged. The GWHNHSFT safeguarding team are not routinely copied into safeguarding referrals made to children's social care. The opportunity to collate the number or quality of referrals, identify trends and to inform the trust board or commissioners about practice improvement is also therefore lost.

5.2.7 The CED clinical governance group is process focused rather than concentrating on whether the attendance at CED resulted in the best outcome for the child. Approaches to addressing poor safeguarding practice by clinical staff are underdeveloped and are not considered at the clinical governance group. Although it is a valuable tool to steer staff's risk assessment, completion of the safeguarding checklist is not the end in itself. However, this was the focus of the clinical governance group in response to poor practice identified by the designated doctor and discussed at its November 2013 meeting. We saw cases where although the checklist had not been completed, the clinician's risk assessment was comprehensive, well evidenced in their case notes and appropriate action had been taken to protect the child.

5.2.8 The school nurse service's recent adoption of a best practice model of case recording (ROPE) is a very positive development. Practitioners told us that the new model facilitates a sharper focus on effective risk assessment and outcome planning with families and is supporting improved safeguarding practice. Records in this service were well ordered making it easy to track the child's journey and are regularly audited in supervision. In services where both hard copy and electronic recording systems are operating, we identified a number of instances where information had not been transferred effectively or accurately between the two and this does create some risk of information being lost or misconstrued.

5.2.9 There is variable recording practice across services overall. At GWH CED, some clinicians hand written notes on the CED CAS cards are illegible rendering the recording ineffective. We also saw mixed standards of recording practice and case record organisation in the looked-after child health team, midwifery, CAMHS and the health visitor service. Case record recording on cases we reviewed in AWP adult mental health services was good: attention being given to recording ethnicity and whether interpreting services were required. However, case discussions in supervision are not recorded on the individual's case record in AWP and this is not compliant with best practice (recommendation 1.4).

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## 5.3 Training and Supervision

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5.3.1 Reception staff at GWH CED are appropriately supported in discharging their safeguarding responsibilities by receiving level 2 safeguarding training. GWHNHSFT is raising the safeguarding training expectation for clinical staff in ED and minor injuries units (MIU) to level 3 competency (*Working Together 2013*).

5.3.2 Although not all the nurse practitioners at SEQOL's urgent care centre are paediatric trained, the skill mix employed in the team allows specialism and expertise in paediatrics to be shared with all the nurse practitioners. Practitioners with paediatric specialisms are driving forward training and development for all staff however, level 3 safeguarding training is not yet a requirement for UCC staff and this is a gap given their high level of contact with children and families (recommendation 6.1).

5.3.3 Safeguarding training being undertaken by all clinical practitioners in CRI equates to level 3 competency levels set out in *Working Together 2013* with advanced training for managers and safeguarding supervisors. All clinical practitioners in AWP adult mental health service will have completed level 3 training by the end of March 2014. Level 3 training for GP's is not consistent or monitored at present and we are not confident that GPs demonstrate a sufficient level of knowledge and understanding of children's safeguarding, particularly in practices in areas of the borough where there are significant levels of children likely to be at risk. A lack of recognised formal training for non-clinical reception staff in GP practices is also an area of concern. We did see positive learning from a significant event in one practice leading to the development of a formal safeguarding protocol and guidelines for referral to children's social care however, these are basic CQC registration requirements which should be well established.

5.3.4 The development of keyworkers with special interests and training in the locality health visitor and school nurse teams is facilitating skill development in frontline community health services. Opportunities for health visitor teams to update their knowledge of safeguarding at the quarterly professionals meetings is helping to ensure that the knowledge and understanding of practitioners of safeguarding issues is current.

5.3.5 Supervision arrangements are variable across services and are not robust in some services which are overly reliant on informal ad hoc supervision at the request of the practitioner. In midwifery, whereas a formal policy for supervision is in place, protected time for individual and group supervision is not routine practice. The service aims to provide alternating group and 1:1 supervision three to four times per year. This is a low level of provision compared to other trusts we have reviewed and midwives told us that this expected level of supervision support is not happening currently. The need for GWHNHSFT to ensure that supervision arrangements are operating in line with statutory guidance has been raised previously with the trust and remains a priority area for improvement. Given the nature and complexity of the work of midwives and the vital role they play in safeguarding the most vulnerable children, effective support to practitioners is essential (recommendation 3.8).

5.3.6 Arrangements for formal supervision in health visitor, school nurse and family nurse partnership services are well established and support practice well. There is no formal, documented safeguarding supervision for paediatricians as set out in statutory guidance however.

5.3.7 The health visitor service is being developed in line with the National 'Call to Action' and eight student health visitors began training in September 2013 at which time seven newly qualified health visitors were also recruited. An accredited programme of health visitor development for the existing workforce including motivational interviewing has been introduced alongside the implementation of the new Healthy Child programme.

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## Recommendations

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### **1 Swindon CCG with Swindon Borough Council and Avon & Wiltshire NHS Partnership Trust should ensure;**

- 1.1 the establishment of an effective perinatal mental health service and participation of adult mental health in maternity liaison meetings in order that new and expectant mothers requiring support for mental health issues have prompt access to appropriate services.
- 1.2 there is effective liaison and sharing of expertise with other health professionals in child protection cases including the undertaking of joint visits as appropriate.
- 1.3 there is full and consistent participation of adult mental health in child in need and child protection processes.
- 1.4 that where discussions of cases take place in practitioners' supervision, these and the decisions taken are recorded on the client record.

### **2 Swindon CCG with Swindon Borough Council and Oxford Health NHS Foundation Trust should ensure;**

- 2.1 that children and young people including those who are looked after have timely access to CAMHS early help and specialist services.
- 2.2 that the pilot complex case consultations are held sufficiently frequently to avoid delays in young people accessing appropriate services and are subject to effective evaluation to determine impact.
- 2.3 where looked-after children are engaged with CAMHS, progress reports are submitted to the looked-after children's health team as requested.
- 2.4 where safeguarding referrals to children's social care are made by telephone, these are routinely followed up in writing and recorded on the young person's case record according to agreed protocol and they are subject to quality assurance checks.

### **3 Swindon CCG with Swindon Borough Council and Great Western Hospitals NHS Foundation Trust should ensure;**

- 3.1 that children and young people who are looked after benefit from quality, timely and comprehensive initial and review health assessments subject to effective quality assurance and robust performance management and reporting arrangements.
- 3.2 that health care plans, developed promptly following assessment, are SMART, setting out clear and measurable health objectives for the child and identifying those accountable for the delivery of outcomes within defined timescales.
- 3.3 that recording practice within the looked-after children's health service is of a satisfactory standard, accurately reflects operational practice and is subject to effective managerial oversight.
- 3.4 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.
- 3.5 appropriate delegation of governance and operational responsibilities in respect of the looked-after children's health service in light of changed commissioning arrangements.
- 3.6 that safeguarding practice within the children's emergency department is of a high standard and subject to effective clinical oversight and robust governance arrangements.
- 3.7 that notifications of a young person's attendance at the children's emergency department are routinely sent to primary care and community health services and convey all pertinent information to ensure effective on-going health support.
- 3.8 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.

### **4 CRI should ensure;**

- 4.1 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.
- 4.2 there is full and consistent participation of practitioners in child in need and child protection processes.

## **5 NHS England Area Team in partnership with the CCG should ensure;**

- 5.1 that GPs have good access to effective safeguarding leadership and guidance and that they understand how to access this to improve safeguarding practice in primary care.
- 5.2 that GPs and primary care practice staff are appropriately trained in line with statutory and registration requirements, fully engaged with children's safeguarding arrangements and participating in looked after children and child protection processes.
- 5.3 that GPs are engaged effectively with the multi-agency risk panel (MARP) and MARAC/MAPPA and have a good understanding of the risk management operating protocol.

## **6 Swindon CCG with Swindon Borough Council and SEQOL should ensure;**

- 6.1 That clinical and non-clinical staff at the urgent care centre undertake child safeguarding training at levels commensurate with their roles and responsibilities in line with *Working Together 2013*.

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## Next Steps

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

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