

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

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

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| Date of review: | 10 th February 2014 – 14 th February 2014 |
| Date of publication: | 1 st May 2014 |
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| Provider services included: | Heartlands Hospital NHS Foundation Trust; Birmingham and Solihull NHS Mental Health Trust; Solihull Integrated Addiction Services (SIAS) |
| CCGs included: | Solihull CCG; Birmingham Cross City CCG |
| NHS England area: | Birmingham and Black Country Area Team |
| CQC region: | Central East |
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Contents

| | |
|-------------------------------|-----------|
| Summary of the review | 3 |
| About the review | 3 |
| How we carried out the review | 4 |
| Context of the review | 4 |
| The report | 6 |
| What people told us | 7 |
| The child's journey | 8 |
| Early help | 8 |
| Children in need | 16 |
| Child protection | 20 |
| Looked after children | 24 |
| Management | 26 |
| Leadership & management | 26 |
| Governance | 31 |
| Training and supervision | 34 |
| Recommendations | 35 |
| Next steps | 39 |

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Solihull. 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 NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

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

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 and families. 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 60 children and young people. We have included some of their stories to illustrate areas of good and poor practice or to demonstrate service provision.

Context of the review

Solihull Metropolitan Borough Council is a single tier authority within the West Midlands region. The borough comprises very distinct areas including affluent areas in the south but to the north, there is a higher population density and greater level of deprivation and health inequality in the three regeneration areas which rank in the 5th most deprived in the country. The life expectancy gap between the most and least affluent areas is significant. 22% of all children live in the small geographical area of the regeneration zone. More than half of children in poverty in Solihull live in this area and the largest cohort of children there is under 4 years old. The Borough has just under a quarter of the population under 20 years of age. About 20 per cent of school aged children are from a black or minority ethnic group, and Solihull has a significant though reducing unaccompanied asylum seeking children (UASC) population. The urban west has the highest proportion of BME children, 22% of the total child population in that area. On the whole the health and well-being of children in Solihull is variable compared with the England average. Whilst many child health indicators are positive overall, this masks distinct 'hot spots' such as teenage pregnancy in some wards. Both the infant and child mortality rates for Solihull are similar to the England average. The rate of children looked after as at March 2012 per 10,000 children under 18 was significantly greater than the England average.

The majority of Solihull's 207,000 residents are registered with GPs within the 32 practices in the NHS Solihull Clinical Commissioning Group (CCG) which in total cover 239,000 patients. The Sirius locality covers the area of south Solihull, including the wards of Blythe, Dorridge & Hockley Heath, Elmdon, Knowle, Lyndon, Meriden, Olton, Shirley East, Shirley South, Shirley West, Silhil, St. Alphage and the area of the Bickenhill ward south of the A45. The Solis locality covers the area of north Solihull, namely the wards of Castle Bromwich, Chelmsley Wood, Kingshurst & Fordbridge, Smiths Wood and the area of the Bickenhill ward north of the A45.

Service provision

Acute hospital services for children are mainly provided by the Heart of England NHS Foundation Trust (HEFT) at Solihull hospital, and at Heartlands and Good Hope Hospitals in Birmingham. HEFT is also the provider of health visiting, school nursing and children's specialist and therapy services, the looked after children health service and designated roles, most sexual health services, most child and adolescent mental health services (CAMHS) and specialist emotional wellbeing services for looked after and adopted children. Birmingham and Solihull Mental Health NHS Trust (BSMHFT) provides mental health care for people living in Birmingham and Solihull and a substitute prescribing and health care service for Solihull residents.

Drug and alcohol services are provided by a partnership of several organisations known as SIAS (Solihull Integrated Addiction Services). SIAS includes BSMHFT and Welcome, a third sector organisation. Welcome provides the hidden harm service for young people. Solihull MBC provides Str8 Up, the young people's drug and alcohol service.

Coventry and Warwickshire Partnership NHS Trust which is not included in this review also provides some mental health and learning disability services for children and young adults who are Solihull residents.

Commissioning

Commissioning and planning of health services is led through the local strategic partnership, with Solihull CCG and Solihull Metropolitan Borough Council the lead commissioners. Commissioning arrangements for looked-after children's health are the responsibility of Solihull Clinical Commissioning Group.

Commissioning and planning of non-specialised health services for children is carried out by Solihull Metropolitan Borough Council (SMBC) on behalf of Solihull Clinical Commissioning Group (SCCG) under a S75 agreement; This includes children's health services such as speech and language therapy, occupational therapy (OT) and physiotherapies. Commissioning and planning of community and secondary care paediatric services is carried out by Solihull CCG. Birmingham Cross City CCG commissions adult mental health services for Solihull within a sub-regional arrangement.

NHS England Area Team (Birmingham and Black Country) commissions health visiting, primary care and a range of specialist services including perinatal in-patient services and CAMHS in-patient (tier 4) services, and HIV treatment services.

Child and adult substance misuse services, school nursing services and contraception and sexual health services (CASH) and genito urinary medicine services (GUM) are commissioned by Public Health, Solihull Metropolitan Borough Council (SMBC).

The last inspection of health services for Solihull's children took place in November 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The safeguarding inspection 'Contribution of health agencies to keeping children and young people safe' outcome was assessed as 'Good'. The looked after children inspection 'Being healthy' outcome was assessed as 'inadequate'. Both the 'Overall effectiveness of the safeguarding services' and the 'Overall effectiveness of services for looked after children and young people' outcomes were assessed as 'inadequate'. Recommendations from that inspection are covered in this 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

We spoke to a number of foster carers who were generally very positive about the support they have received from health professionals.

Young people and carers spoken to particularly praised the dedication and persistence of the designated nurse and doctor in working to improve their health and wellbeing.

“She is amazing, never known a LAC nurse like her, she’s such a support, both practically and emotionally. One child I am caring for had a health problem that was very tricky and became really serious. The LAC nurse helped us through all that”.

“There is now more choice about time and location of health assessment”
“The LAC doctor gets back to you and will follow things up. Things have much improved since she took up her post”

The approach of the LAATCH team was valued, seen to be enabling and effective in preventing placement breakdown :

“Without them I might have been at the point of going under. The children have very complex needs, they have been through so much. LAATCH have a very empowering way of working, you feel you can do it. We work as a team, it’s a group effort. The girls are really thriving now”.

One foster carer would welcome a helpline where they could get some support with understanding/managing the care of child placed with them until the CAMHS appointment came through.

The contribution of GPs and health visitors was also praised

“Knowle surgery is fantastic. They all know the patients really well, they listen and treat you as equals”

“The health visitor comes to my home and listens to any problems I am having”.

Another foster carer highlighted that their local surgery did not seem to know they were a foster carer and thought GP surgeries needed to give a higher priority to the health care needs of the child they were caring for.

We heard about some delays in young people being able to access the help they needed. A foster carer of a child with learning disabilities:

“We had to wait a long time for an orthodontic appointment – 7 months. It’s a long time. But the dentist is very sensitive and understanding of her needs”.

One foster carer expressed concerns about the need for greater awareness by reception staff in a variety of settings to maintain confidentiality of the addresses children are placed at.

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

Assessing Need and Providing Early Help:

1.1 Local strategic partnership plans are giving high priority to ensuring that children and their families can access help early when it is needed. Some parents and their children currently benefit from early help services including the children's centre network and some effective partnership work by health practitioners, social care and schools. Extending the reach, range and effectiveness of this early help is a key local strategic priority for Solihull. We found that health professionals' are putting in place improvements to their systems to identify and support children and families. However, arrangements would be strengthened by more focus on: ensuring that systems are more robust; ensuring that there is clarity of role at individual, team and service level and clarifying expectations and standards in multi-agency working to identify needs and support families (recommendation 5.1).

1.2 Once booked for maternity services, mothers to be can self-refer to additional specialist midwifery services. Consultant-led care is mainly delivered at or by Heartlands (BHH) hospital; women can also opt for shared care between the hospital and their GP. In these cases information sharing between the GP and BHH can be complex due to different IT systems (recommendation 4.13). Where delivery is expected to be uncomplicated, women can book at the popular midwife-led birthing unit at Solihull hospital. Midwifery staff try to support women to achieve a birth plan which best meets their needs.

1.3 Women and fathers who have learning disabilities do not have a clear pathway to ensure they have appropriately adapted support or information to help them understand pregnancy and develop their skills in baby care. In these examples good individualised care was arranged but managers recognise that the quality of the midwifery work could be strengthened through tighter screening and support for women with dual needs or specific learning disabilities (recommendation 4.14).

Midwifery staff at Solihull hospital and BHH worked together with the family of a young woman with autism and physical health concerns. The usual pathway would be for delivery at BHH because of her physical health. The family and staff negotiated a local plan with BHH. Through regular monitoring of potential health risks which remained stable, she was enabled to have a positive experience of antenatal care and 1:1 delivery in the surroundings at Solihull in which she was already comfortable.

We saw a case where both parents had learning disabilities; the mother was referred to the mental health specialist midwife. In view of the additional range of vulnerabilities, midwifery alerted health visiting and social care before the birth. Risks and complexity of need were identified early by midwives and a pre-birth conference took place and decided that the baby was at risk of harm.

After discharge there was regular home visiting by health visiting and at this point a student health visitor was able to do some additional work to help the parents to understand their caring responsibilities. The family is now in an external assessment placement.

A clear learning disability specialist pathway would help to ensure parents are properly supported and also that they have advocacy to help them understand the processes.

1.4 In other respects, access to the resources of a large trust such as HEFT with one of the country's highest birth numbers, means that Solihull women are supported by midwives with a wide range of specialist skills. Women with drug or alcohol misuse problems have good access to specialist advice and can quickly access appointments at the drug and alcohol service Solihull Integrated Addiction Services (SIAS). A small number of women with very specialised needs also benefit from the input of a highly regarded specialist FGM¹ midwife who trains local midwives as part of the three year delivery skills refresher training, and also trains regionally and nationally. Solihull hospital has a midwife with a special interest in mental health and women can be supported by an antenatal mental health liaison clinic served by a perinatal psychiatric nurse and a consultant perinatal psychiatrist employed by BSMHFT. The experienced domestic violence specialist midwife attends multi-agency risk assessment conferences (MARACs) coupled with other joint screening arrangements, achieves good results in her support for women and also helps other agencies to gain confidence.

1.5 Young women who become pregnant have support from a teenage pregnancy midwife. The addition of a family nurse partnership in the borough has added to supports for young parents. Although we did not see examples of their work and its outcomes we heard that joint working with the three family nurses is enabling better engagement of young people throughout their pregnancies.

¹ FGM –female genital mutilation

1.6 Midwives promptly highlight and follow up significant concerns in relation to the health and wellbeing of mothers or the safety of their unborn babies. Maternity checks for domestic abuse are clearly flagged and monitored. Communication with the police and health visiting about causes for concern has improved. This includes more checks on males, and other people in the household. Good use is made of the expertise of specialist midwives in managing risk. We found that midwifery discharge arrangements ensure that women receive a prompt midwifery visit when they return home. Where other key agencies are supporting a family there are arrangements to ensure that they are generally involved in discharge planning. Some mothers to be receive an antenatal midwifery home visit to focus on the environment, but this is inconsistent practice. Standardising this approach would strengthen support and safeguarding for new mothers and their babies. A midwife will normally make a follow up visit the day after a baby returns home although with experienced mothers a phone call may be made to find out whether a visit is wanted. Additional visits may be made in accordance with a mother's care plan.

1.7 The local health economy has undertaken reviews of communication; information sharing and partnership working following a serious case review and has plans in place for improvement work. We saw some examples of effective liaison between agencies but also found that arrangements could be strengthened through further development and embedding of joint working arrangements to support families and children effectively.

1.8 We heard that midwifery is currently looking to strengthen perinatal mental health pathways to ensure they are fully compliant with the NICE² pathway. Safeguarding unborn babies and young children is a clear shared local priority. This example demonstrates the value of vigilance of hospital staff and how communication with the GP helped to safeguard an unborn baby:

A pregnant woman transferred in from another area and booked into BHH for antenatal care. Hospital staff noticed her partner addressed her by a different name. They contacted the GP who found there had been a lot of social care involvement with the family in the past. Agencies were able to work together to assess and monitor risks to the unborn baby.

1.9 We heard how information sharing between midwives and health visitors is improving. New systems are in place that promote earlier recognition of vulnerable women who may require a higher level of support from the health visitor team on discharge from hospital. However, internal audits and discussions with frontline professionals indicate this is an area where the required standard of practice is not yet fully embedded however (recommendation 5.3). We saw some case examples where insufficient information was available to health visiting practitioners:

² NICE – national institute for clinical excellence – provides guidance on quality standards for health pathways

In both north and south areas we saw example cases where mothers to be received appropriate antenatal risk assessment and care in respect of a history of depression. Neither case warranted a pre-birth safeguarding referral but health visitor feedback highlights the need for improved communication from community midwifery so that health visiting is more aware of the potential for post natal concerns.

In one case increased risks were identified shortly after the birth and mental health services provided good care and oversight in conjunction with the GP and health visitor. In the other case an experienced health visitor identified during a routine core visit that the mother was becoming over whelmed and visited a second time, which led to further risks being identified including the potential to harm her baby. Very prompt joint working between health visiting, GP and specialist services was able to secure the well-being of the family. The initial handover form didn't provide sufficient hand over information.

1.10 For the majority of new mothers who do not have support through a specialist pathway, routine post natal 'hand over' arrangements from midwives to health visiting teams use hand written forms as IT systems do not currently provide automatic notifications. New arrangements are to be implemented to systemise this handover but we saw a collection of 'routine' midwifery to health visiting hand over forms which were hard to read and scant in detail. This means pertinent historical risks may not be fully apparent to inform health visiting priorities, as we saw in a case above. Improving the quality of hand over information is an area for further work (recommendation 5.3).

1.11 Where they are in place, links between GPs and community midwives help to co-ordinate care and identify concerns; in one practice we visited midwives hold a weekly surgery at the GP practice. Midwives reported the need for stronger engagement and information sharing from community mental health teams (CMHTs) in assessing risks and the planning of support to parents with mental health needs who fall below the threshold for specialist perinatal consultant services (recommendation 5.3).

1.12 Mental health services are increasing their focus on 'think family' in work with parents who have mental health needs, managers acknowledged the need to further strengthen the practical application of the approach. We identified work that suggests that 'think family' is not adequately understood or shaping local practice on a consistent basis. An example is a mental health record that did not adequately consider risk in the context of parental responsibility and history of self-harming (recommendation 6.5). The importance of professionals' thorough understanding of 'think family' and of the potential value of multi-disciplinary working is exemplified in the following case we looked at from both midwifery and mental health perspectives and discussed with the named nurse.

The perinatal specialist midwife was involved from the outset of the pregnancy of a single mother to be with a previous history of depression and self-harm. A referral in respect of the baby was also made to health visiting using the neonatal alert form. However, there was no direct liaison with health visiting and no checks, information sharing or follow up are evident in respect of her two young children, initially or since . During this time a number of risks to the mothers' mental health have been identified and she has expressed concerns about the pressures of coping with the family to mental health professionals.

The CPN and perinatal mental health staff have provided good scrutiny of risks and support for the mother in terms of her health. However the mental health record does not adequately consider risk in the context of parental responsibility and history of self-harming and the need for early help and focus on the needs of the children (recommendation 7.1).

In terms of liaison with universal health services such as health visiting and school nursing, the current referral has focused on future need for support to the unborn baby, and it appears that the impact on the other children has not been addressed. Due to pressures on universal services, they have less routine contact with children unless concerns are flagged up to them (recommendation 4.10).

1.13 HEFT community services recognise there is more to be done to establishing more robust and timely information sharing to and from health visiting and school nursing is also particularly important as workload is being managed through corporate case loads. This means that families often have different health professionals involved in their care and runs the risk that relationships may not be sufficiently developed with some parents and changes in the baby's care or presentation may not be promptly identified. Community staff may not have prior knowledge of the families they visit and are reliant on the quality of information available to them (5.3).

1.14 Community psychiatric nurses attached to children's centres are regarded as a valuable early help resource, able to respond quickly to early signs of parental mental distress. Some professionals raised concerns about future risks if this service was not sustained.

1.15 We saw examples where the drug and alcohol services work cooperatively with other professionals, recognising their role in safeguarding the needs of children in families who are affected. They share information well and recognise and promptly respond to increases in levels of risk. However, within this good work, more attention is needed to clarifying the impact of parental substance misuse and risky patterns of behaviour and ensuring this information is clearly shared with child health and social care professionals (recommendation 5.3). We also found that appreciation of the impact on children of parental alcohol and substance misuse and of domestic violence is not always fully reflected in the safeguarding work and risk assessments of other agencies, for instance health visiting and school nursing (recommendation 3.2).

1.16 Appropriate follow up and support is available for most young people attending hospitals emergency departments. Systems for routine tracking and follow up of young people under the age of 16 are mostly effective, but across all the hospitals serving the borough's children, further consideration is required to strengthen alerts in relation to vulnerable young people 16-19 years including care leavers (recommendation 4.5). Further thought also needs to be given to ensuring young people are seen alone, and to ensuring their comments are consistently recorded within the assessment process (recommendation 4.8). Some GPs highlighted the need for hospital discharge summaries to contain more information about presentations at emergency care to be kept up to date about the outcome of referrals, and future management plans in a timelier manner (recommendation 4.9).

1.17 Building on the existing programme of midwifery-led antenatal classes in providing early help, we heard about an innovative new five-week parent craft programme for expectant parents which has just been piloted in one district and is about to be extended borough wide. Midwife –led but working with children's centre staff, the programme includes special focus on helping parents to understand attachment and child development and this has the potential to establish good parenting at the earliest stage.

1.18 GPs are vigilant in identifying babies and young children who have not had their immunisations. We found that most families with pre-school children are receiving the core level of support as part of the 'Healthy Child Programme', through a combination of visits and clinic appointments offered by health visitors and nursery nurses. Mothers to be should benefit from the implementation of routine ante natal health visits which are to be supported by a local financially supported target for 2014-15. Currently this is a gap, even for vulnerable families, which could result in a missed opportunity to identify any emerging concerns and delay in any subsequent offer of support. Stretched capacity in health visiting teams is under further pressure in covering annual leave and sickness, especially an issue in a small team (recommendation 4.12).

1.19 Regular and routine availability of school nurses in supporting the well-being of school age children through delivery of the 'Healthy Child Programme' is not in place. The capacity of school nursing is extremely stretched. Work is currently being managed as a single corporate caseload which is focussed on the delivery of risk assessed highest priority work in health care planning for children with complex health needs and children already in the child protection system. This means that nurses are less visible and risks local intelligence being missed. We saw the impact on nurses' availability to support individuals and targeted groups at an early stage. Efforts have been made to ensure that each secondary school has a named nurse, but as each nurse covers two to three of these schools, their time to establish relationships is very limited. Primary schools no longer receive regular visits or have named nurses. These constraints result in the role of school nurses in tier 2 CAMHS provision also currently being very limited. In some of the cases we saw, the valuable potential role of school nursing in supporting young people's emotional well-being and health appeared to have insufficient recognition by other professionals working with the child.

1.20 Health services in the Borough are seeing an increasing number of young people who self-harm. Better coordination of health supports could improve the effectiveness and timeliness of help. As an example, young people can be referred urgently to CAMHs, but where they do not have supportive parenting, we saw examples of extended drift before the children were able to access the help they needed. Tighter planning and clarity about responsibilities and time frames and improved multi-agency health involvement in their plans could improve both risk assessment and young people's engagement and access to services (recommendation 6.3).

1.21 Work currently undertaken by CAMHs is rated as good by other professionals and foster carers to whom we spoke. The multi-agency team (EHMAP) which prioritises referrals takes a child centred approach to the needs of each child by suggesting alternatives where the referral is not accepted by CAMHS. We also heard that young people with significant needs have the benefit of specialist Tier 3 outreach support which prevents hospital admissions in almost all cases. This is borne out in that only 10 young people have required admission to Tier 4 placements in the last 10 years.

1.22 Current arrangements are not effective in ensuring that young people referred to CAMHS because of emotional or mental health needs are offered targeted support through school nursing. We saw case examples and heard from nurses that they are not made aware of CAMHS referrals or engagement unless they made the referral. The administrative arrangement for the school nursing service to receive weekly lists of young people being considered at the EHMAP meetings has proven insufficient to ensure the right people receive the information in timely fashion as school nursing is not represented at these meetings. Gaps or barriers in information sharing such as this have been a feature of several national serious case reviews. In this case we saw how it impacts on school nurses' ability to recognise that these are children who may need additional support (recommendation 4.13).

1.23 The CAMH service operates a daily screening of the urgency of referrals which includes the assessment and management of any risks. Families are advised when contacted to monitor young people and to present to A&E if they feel they cannot keep their child safe. Solihull CAMHS is currently not commissioned to provide an out of hour's service or a crisis response for referrals. Young people in emotional distress can be affected by this recognised gap in out of hours CAMHS services when it results in them having to wait on wards for a psychiatric assessment when they are otherwise medically fit for discharge. This largely relates to young people who self-harm from Friday onwards and who have to wait until Monday before they can be assessed and safely discharged (recommendation 1.5).

1.24 We heard about some issues in terms of the length of time between referral to specialist CAMHS and service start. We also saw some difficulties in achieving successful referrals to the service which may be linked to making sure all professionals' have proper understanding about access criteria and the key information needed to meet the threshold for specialist CAMHS (recommendation 1.3). One case in particular stood out as an example of a GP's referral being considered insufficient to meet CAMHS criteria whilst other professionals could see that the child had considerable need for therapeutic support.

At 13, young person Y already had a two year history of self-harm and had earlier been referred to CAMHS (but didn't engage) prior to the GPs referral in March 2013 when Y was 13. During this period it is unclear to the school nurse and in records whether the young person was assessed as being a child in need.

This CAMHS referral was not accepted on the grounds that the young person 'does not have complex or pervasive mental health needs.' Y again self-harmed and was treated at hospital in autumn of 2013 and early in 2014 after which Y was seen on the ward by CAMHS and offered follow up.

1.25 This case also indicates that there are limited options available for preventative and specialist services to support young people who are at risk of self-harm. Current arrangements are not ensuring that these young people receive prompt early help (recommendation 4.6).

1.26 Accessibility to the adult drug treatment service is being improved as a result of the new contract which recognises that the location of the main service base in the north presented accessibility difficulties for people in other areas of the borough. From April, parents in the southern wards will find it easier to access help through a new base in the south.

1.27 The Just 4 U website provides a range of information to help young people understand services locally available. All sexual health clinics are 'You're Welcome'³ accredited. Young people were involved in the service review consultations about locations and times of services they wished to access. Young people now have good access to CASH clinics and contraceptive services are also available from GPs and pharmacists. However, further work is required to ensure service take up reflects the diversity of the local area and continues to effectively engage boys and young men.

1.28 Electronic records systems within the acute trust are able to identify children who attend multiple sites and those with a child protection plan if they present at any of the three hospitals. Paediatric nursing and medical staff at Solihull and Heartlands Hospitals are alert to risks to children and young people and appropriately refer concerns onto children's social care. However, emergency staff are not consistently checking and/or recording that they have checked if the child/young person is on a child protection plan (recommendation 4.7).

1.29 Arrangements to identify other vulnerable children who attend for urgent care and to ensure they receive the help they need, are mostly good. The paediatric nurse liaison (PLN) service at HEFT's Heartlands and Good Hope hospitals is provided by the Birmingham Community Trust. Very stretched capacity impacts on Solihull families attending these hospitals, with one health visitor responsible for the liaison about all children who present from any local authority area across the hospital sites (recommendation 4.15). The volume of activity is therefore high, the nurse having on the day we visited reviewed 205 records, of which 35 related to Solihull and resulted in three notifications being made

³ A national scheme to assess and accredit services that are young person-friendly

1.30 We saw very effective paediatric liaison at Solihull Hospital, with the experienced practitioner also working to improve information flow and systems across all hospitals. We did though, see an example of current difficulties in timely sharing of information about looked after children who attend Birmingham hospitals which use a different IT system which is unable to flag up Solihull's children in care. In this case the young person with complex needs attended urgent care and was admitted to a Birmingham hospital for a lengthy period without the looked after (LAC) nurse being informed. The LAC nurse's concerns were taken on board in contacting her about a subsequent readmission of the same young person however. The issue of identifying looked after children and sharing information across boundaries is subject to a new work around to improve information flow. This is an issue which should be kept under tight review.

1.31 We heard from some professionals and foster carers about the impact on children where they experience delays in securing help from the speech and language service. Although families are usually seen for a screening appointment within four weeks, some children then have to wait a lengthy period before they can access therapeutic support, for instance we heard of waiting times of 42 weeks and in one case we saw, the looked after child had so far been waiting more than six months (recommendation 1.4).

2. Children in Need

2.1 We heard how systems and partnership working to identify and support children in need and those who would benefit from early help have been reviewed but it was too early to see the benefits of the new multi-agency panels (MAPs). We heard from a range of professionals about the value of the weekly CAMHS EHMAP in identifying alternative sources of support for young people. Unfortunately, health visiting and school nursing are absent from EHMAP referral meetings which is a barrier to ensuring full and expert consideration of risks and impacts on children's health.

2.2 There is scope for health professionals to be more aware of and involved in children in need processes and individual plans to ensure that the health needs of these children are appropriately supported (recommendation 5.1).

We followed one case of a young teenager for whom an urgent referral was made to CAMHS by their school as a result of low mood and self-harming. CAMHS was told that the child was a child in need but CAMHS was not part of any CIN plan. As a result, opportunities to help the young person were insufficiently focussed for most of 2013. School nursing records showed no contact by the school, social care, CAMHS or GP nor had school nursing been informed either of the child in need status or the CAMHS referral. School nursing was unaware of any concerns until invited to an initial child protection conference almost a year after the CAMHS referral.

Although there are arrangements to fast track entry to CAMHS, we saw how, in this urgent case, the young person did not start to receive help for a long time. Once a referral is accepted, even as an urgent case, young people can still experience delays before being seen for a "Choices" initial appointment and then waiting for the service required.

In this case it was agreed by the MAP that this child should be offered an appointment within 2 weeks; this was deferred by a further week and the initial appointment offered was for 6 weeks after the referral. Chaotic family life wasn't supportive of the child's engagement and other supports were not set up to help the child to take up services. In the event the family cancelled the first appointment and it was 6 months before the child's Choices appointment.

2.3 Midwives are increasingly recognising their potential role in CAF work but managers are trying to secure some capacity to support their regular engagement. Universal services are likely to have a more ongoing role in 'team around the family' (TAF) work but again, current capacity issues and focus on core work impacts on their availability. We only found one recent case where health visitors were undertaking the lead professional role. In this case good outcomes were achieved from the CAF work undertaken with a mother with mental health needs. There are difficulties in implementing CAF as engagement of adult mental health and information sharing in relation to CAF processes is not well embedded (recommendation 5.1). School nursing recognises their role but struggles with capacity to take the lead in TAFs.

2.4 Young people have easy access routes into the ST8up service which offers a flexible responsive service to young people with drug or alcohol issues. The small staff team is well qualified and trained to offer a range of interventions which are also available to children of users. Feedback from young people affirms the value and success of the service and the extent to which staff support each individual to achieve their goals. A simple to use screening tool (DUST) is used by St8up and well promoted in the borough as a consistent tool for other professionals who work with young people.

2.5 Many children and young people also benefit from the expertise of staff at the Meadow Centre, a dedicated specialist service providing multidisciplinary assessment advice and support for children and their families with significant and complex medical, developmental and or social needs. Two teams support children with disabilities up to 18 years old, one for younger children up to 6 years of age and the other for older children. We heard from a foster carer about good outcomes from her experience with several children having used this service although they had considerable waiting times for assessments.

2.6 Some young people with complex health needs are not having these needs adequately recognised so that they get the help they need. We saw an example of dedicated work by a school nurse in trying to help a family overcome the difficulties experienced by children and their families who do not meet the criteria for these services or have dual diagnoses and are not accepted by either service.

Teenager Q was borne with several congenital health issues although accesses mainstream schooling. A school nurse became involved in order to provide support for a personal care problem. It was obvious to her that the young person and the family were experiencing significant emotional difficulties linked to the transition to adulthood. The young person was becoming more depressed and his turmoil transferred to his home and presented safeguarding concerns for himself and the family who were in need of respite. The young person was also very isolated and lacked advocacy for expressing their feelings.

The school nurse made referrals to several services which were all turned down. The CWD service has high thresholds but the family found there was no other service available to support the parents or Q with physical and emotional needs or respite. The information in the first referral to CAMHS was not considered to warrant CAMHS but a TAF and respite care were suggested. A further referral by the school nurse provided additional information to suggest the young person met the CAMHS criteria to offer a Choice appointment.

The school nurse, working with a TAF led by school, has continued to support the family in securing some help for Q and maintains continuity in support for Q.

2.7 Some children of parents whose own difficulties impact on their parenting ability require stronger recognition and support. Cases seen of young people entering care later in childhood highlight the need for additional support to prevent family breakdown. The role and contribution of health to preventative or step down work in these cases requires further development (recommendation 6.7).

2.8 We saw many examples of health professionals working very co-operatively with a range of disciplines to support vulnerable children about whom they have concerns. However, we have also seen a small number of examples such as that above where indicators of risks to children have not been shared with all relevant health professionals, and have not been identified or recognised for their significance. As a result, risks to some individual children have not been fully investigated and addressed promptly. More attention is required to ensuring that communication, information sharing and partnership working is timely and effectively coordinated (recommendation 5.3 (systems) and 6.2 (understanding and engagement)).

2.9 Health professionals in all disciplines are increasingly confident about being open about their concerns and the action they propose to take. In one of the cases we saw, a GP who had concerns about a family was clear in his contact with the parent about the reasons for referral to social care. We also heard that some GPs still need to develop confidence in making a referral direct to children's social care rather than, for instance, asking a health visitor to get in touch with a family without any prior explanation to the family (recommendation 4.13).

2.10 Currently the expertise of some key health professionals is not being fully deployed to support wider partnership working in reducing risks. Very low numbers of young people for whom CSE concerns have been identified are using CASH services, suggesting there is either significant under identification and/or information sharing between partner agencies (recommendation 6.2). Within the CASH service we saw appropriate identification of risk to a young person who sought support with contraception. CASH staff appropriately provided a range of advice and stayed in touch with the young person to provide follow up.

2.11 In several cases we saw children with child in need status but there was a lack of planning about health professionals' roles, what was expected and what difference this should make to the children concerned. The escalation threshold was also unclear to health professionals which can cause health practitioners to run with risks that are not being fully considered through multi-agency arrangements (recommendation 5.1).

A 15 year old was left at home unsupervised and isolated for several months when both mother and step father who were known to services were admitted to psychiatric hospital within a short time of each other. Early identification of children within a family enables mental health professionals to work with others to support the whole family. However, we did not see evidence of the child receiving support as a child in need before this, and there was a lack of clear multi-agency planning. It appeared to have taken too long to move from child in need to looked after status given the lack of parental oversight at home. The young person was not identified as a young carer.

2.12 Managing prompt transfer of records between services and teams and ensuring that key information remains available in the host area is another area which HEFT has identified for further work (recommendation 4.13). A case example demonstrated risks in management of child health records when young people transfer to a school out of the Borough as the paper records follow the young person. Accountabilities need to be clearer to ensure the home area is notified about increasing risks/addressing the health needs of children who attend schools out of Borough (recommendation 5.2).

X, a young resident of Solihull was taken to a Birmingham hospital as a result of self-harm. Ward staff at BHH contacted Solihull school nursing seeking information in relation to the Child x. No records were available to SN in Solihull as X had transferred to an out borough school and with him, the records. The SN located the new school and discovered a range of concerns was flagged by the school to the police and social care. X had also been referred to other services but not engaged, but the SN was unaware of any of these facts prior to the young person's hospital admission.

2.13 Health services have a crucial role in identifying and supporting children who may be suffering hidden harm, or for instance, taking on caring responsibilities beyond their years. The Hidden Harm worker in SIAS has a powerful and valuable role helping to improve outcomes for a small number of children referred to her. However, this service is only available to a small number of children who parents misuse drugs or alcohol. We saw how some children may be coping for some time before being referred. In addictions but more especially in mental health work, the impact on children of parental difficulties was insufficiently considered in some case work we saw.

3. Child Protection

3.1 Health professionals feel clear about thresholds for safeguarding referrals. In some cases we have seen referrals being followed up by re-referrals where they believe that their concerns were not being heard. The difficulties in implementing TAF arrangements may be contributing to some cases where individual health agencies feel that they are holding risks for too long outside formal processes.

We saw a case of a teenage mother to be who had previously been 'looked after'. A high number of safeguarding issues about parenting capacity and partner risks were clearly identified and appropriately managed by health professionals. Midwifery promptly made a safeguarding referral in accordance with the local arrangements because of the vulnerability of the mother. The teenage pregnancy and perinatal specialist midwives were also alerted. Health visiting was alerted the following month.

The young person failed to attend several appointments but overall concerns continued to be held by maternity alone. With no formal TAF or safeguarding activity in place prior to the birth, midwives felt they had no vehicle to challenge non attendances or to probe the mothers health needs. Good use was then made of the escalation procedure in this complex case where the young woman is highly vulnerable. A discharge planning meeting was held the day after the baby's birth with social worker and all relevant health professionals involved. Maternity staff were informed the next day that the baby was to be taken into foster care.

3.2 Health practitioners we met are clear about how to make referrals where they have safeguarding concerns. We found that the risks of harm are not always fully and clearly articulated in their referrals. Improving this aspect of work will better enable social care and others to fully understand the referral and appropriately prioritise their risk assessment (recommendation 6.1). We saw the following example at the Bridge, part of the addictions service:

In this case a mother with three school age children had a lengthy history of depression and came to the service as a result of alcohol misuse in 2012. The children were subject to child protection plans and the mother allowed no contact. They were later returned home and made children in need in 2012

Records show that again in 2013, child protection concerns were again reported by school and the mother requested substitute prescribing due to heavy drinking. At such times the children are neglected and there could be violence. The mother's compliance was very patchy and concerns escalated.

The addictions service appropriately made a safeguarding referral as a result of a series of events which were recounted within the referral. However, the referral didn't set out the impact on the children or describe patterns of behaviour or their seriousness which the addictions service is best placed to understand. The children were made subject to child protection but since then the core group actions have also lacked clarity about roles and thresholds.

3.3 We saw examples of good practice across health and social care in pre-birth child protection work. Some midwifery cases demonstrated well the impact of effective, timely multi-agency working to support vulnerable women. In a small number of cases there were midwifery concerns where, following a referral, safeguarding arrangements for an unborn baby were being left too late.

3.4 In both adult mental health and addictions services we identified the need to tighten awareness and practice relating to establishing the details of all adults in a household and their relationships to the child and each other (recommendation 6.6). In a case in the addictions service, where there were concerns about the three children, a new partner was referred to very briefly in records by their first name alone, but without follow up with further enquiries about his identity to inform a risk assessment. Sometime later the partner was again mentioned in a meeting but again, his place within the family was not established. A further example is in another case we saw:

In our review of a case in adult mental health, senior managers highlighted the need to strengthen the focus on all adults living in the household.

The pregnant mother was well monitored by midwifery and perinatal mental health and when risks to the baby were identified, appropriate action was taken. However, records were unclear about the identity of the partner who hadn't been taken into account in assessing risks to the baby.

3.5 Solihull has established an Early Help Multi-Agency Meeting which is attended by Health (including CAMHS), police and social care. It drives offers of early help to families experiencing difficulties and is the mechanism used to screen domestic abuse notifications. Responses and updates to health practitioners safeguarding referrals have become more reliable. Most of the health professionals we met recognised their role in following up safeguarding referrals and assuring themselves of the outcomes but this is not yet fully embedded across all services. In a few cases, for instance a case in CASH, we found that the absence of a response to a referral had not been chased by the service.

3.6 Health visiting and school nurse representation at child protection conferences and meetings has been given high priority within their work allocation and they provide reports as well as attending, which is good practice. The limited presence of school nursing in work other than child protection often limits the extent of the intelligence they are able to contribute about individuals. Given capacity pressures in school health and the high proportionate time taken up by these meetings (70 – 80% of school nurses working time) a new protocol has been put into place to clarify when it is appropriate for school nurses to attend, including their active involvement in a case. Some health agencies in Solihull only provide reports when they are not attending, which is a less robust contribution. The engagement of and contribution of GPs particularly needs attention to overcome barriers and improve the consistency of their contributions (recommendation 2.3).

3.7 There is scope to increase the impact of the CASH service in safeguarding systems. Sexual health workers in the CASH service are insufficiently connected to arrangements for identifying and responding to risks to young people and are not well informed about children on child protection plans who may be at risk from CSE. The service had made only one child protection referral of a young person and staff we met had not received requests for information as part of s47 enquiries or been invited to safeguarding/child protection meetings.

The hidden harm worker and Str8up young people's service work closely with other partners, helping to safeguard children through their expertise. In a recent child protection case involving parental addiction, there was a move to -reduce frequency of support/step down to CIN status but the service insisted this wasn't appropriate as addictive behaviours still presented risks. As a result the decision was made to continue to support the child through a protection plan.

3.8 We heard about the value of practitioners from addictions services contributing to decision making at case conferences and other safeguarding meetings. However, they do not always attend case conferences to present their expertise about addictive behaviours and other professionals often have insufficient experience to understand the impact and take fully into account in considering risks and plans.

3.9 Children and their families who move between areas are safeguarded by mostly good tracking systems. Midwifery services are especially vigilant working across boundaries with other named midwives and heads of midwifery services to safeguard unborn babies.

3.10 The extent of sharing of electronic records is variable between agencies. Some systems are currently being migrated or updated which should improve connectivity in those areas, for instance at SIAS. In areas of work such as mental health and SIAS, paper and electronic records run side by side. It is acknowledged that this can contribute to gaps in understanding about children's known vulnerabilities or safeguarding risks, and about the support that they may be receiving. The launch of a new IT system should address this important issue. However there are currently some barriers to effective practice such as systems in and between school health, midwifery and a small number of GP practices (recommendation 3.3). In some areas of work safeguarding health professionals could benefit from read only access to the council's client information system to enable prompt checks to be made in respect of risks.

3.11 The RiO system used within adult mental health and substance misuse does not currently have an alert to denote where children within a family are on child protection plans. Arising from some case work in both disciplines, action is now being undertaken to strengthen systems and review of risk management practice in relation to children in families. Following immediate action a flagging alert system was incorporated into the system from 17th February 2014 and will be kept under review.

4. Looked after Children

4.1 The looked after children designated nurse and doctor have been effective in raising the quality of health care arrangements for looked after children. We saw evidence of how they are working to embed a culture of child/young person centred care. The nurse's work in engaging older young people who enter care later or who have been resistive to accepting help is exemplary. We also heard from foster carers examples of how the looked after team are going to great lengths to support them and help their children to get the help they need.

4.2 Efforts have been made to ensure assessments are undertaken in a timely manner, although a number of cases seen were not within the required timescales, there is much improved performance since the last inspection, up from 79% to 92% overall (recommendation 4.3).

4.3 The designated team maintains a focus on improving quality and the health reviews we saw in the new format support a better focus on holistic assessment of young people's needs. The review form now presents the opportunity to think about health needs in a much wider context, questions any outstanding needs that can influence health and wellbeing outcomes for this vulnerable group and seeks to set clear health targets with identified timeframes. Overall, the quality of many health assessments is good with some clear and holistic care plans. There is some variability however, where assessments and health plans are insufficient to ensure children's health needs are proactively addressed (recommendation 4.3).

4.4 We saw some inconsistencies in assessments and plans for babies and young children – of a sample of four, two were very good, one adequate and one basic. For children in the mid age range, we saw some examples of assessments where the children's history and the impact of poor life experiences or traumas was not reflected in the initial assessment or subsequent health plan. We also saw some health reviews that were not informed by wider health information that would be relevant. Work seen in relation to children with complex disabilities was insufficiently detailed and health support plans need to be aligned to wider transition arrangements.

4.5 We saw and heard about very positive proactive work with older young people who entered the looked after system at a late age. The designated nurse has successfully promoted improved take up of health assessments by older young people who have previously refused to engage. The nurse offers appointments for looked after young people to be seen for their health assessments at venues and times to suit the individual which is helpful for those reluctant to attend for reviews in clinics. Afterwards she also writes a very personalised letter to each young person thanking them for coming to the appointment and providing a clear outline of next steps. These IHAs and RHAs are comprehensive and supported by SMART health care plans with risks clearly identified and closely monitored.

4.6 Having identified particular issues with the quality of out of area reviews, the designated team has also improved arrangements for supporting the health needs of children placed outside the borough. The team will now undertake health reviews for children placed up to 50 miles away. We also heard how the designated nurse negotiated an arrangement for one young person who was placed externally, to come into the borough so that her review could be undertaken in the place in which she felt most comfortable.

4.7 The annual 'strengths and difficulties questionnaire'⁴ (SDQ) survey of the emotional wellbeing of children in care is undertaken by social care staff. A recent improvement to arrangements had been agreed for notification of the score to the looked after team prior to the annual review, though this practice was still patchy in practice. SDQ processes could contribute much more to inform health assessments about emotional well-being and risks and their use is not yet sufficiently developed. Work undertaken by CAMHS is also not sufficiently used to inform future individual health planning and monitoring of risks as part of annual reviews (recommendation 4.2).

4.8 We heard positive comments about the role of health visitors and school nurses and their involvement in looked after children work. We found them to be supportive of foster carers caring for new born babies and vulnerable children. We saw some good engagement by some GPs in supporting vulnerable children and heard some positive messages from foster carers about this help. The role of GPs in supporting children in care and care leavers is adequate overall, but would benefit from further development and training (recommendation 3.4). Whilst GPs are provided with copies of children's health assessments and plans, they are not being asked to give their opinion of the child's health in advance of the review, although this would strengthen the arrangements. It is also often not sufficiently clear to them what areas within the child health care plan they need to follow up.

4.9 Health support for care leavers remains under developed and leaving care health passport/summaries are not yet embedded in practice. The local team recognise this and plan to develop health support for care leavers to improve identification of future needs and ensure targeted support for those with ongoing risks to their health, personal safety and wellbeing (recommendation 4.4).

4.10 Systems in use in emergency departments in HEFT's Birmingham hospitals are unable to proactively identify children and young people in the care of Solihull. This means that the vulnerability of some young people, particularly those presenting with self-harming behaviour, may not be clearly identified. Particular attention needs to be paid to assessing any additional risks posed to children in care and care leavers within triage assessments and prior to their discharge. Further review of current practices and opportunities to identify children and young people in the care of Solihull who present at HEFT's Birmingham hospitals has been planned with an A&E information sharing pathway (recommendation 4.5) as well as review of self-harming pathways to ensure a comprehensive response to children and young people who make repeat presentations (recommendation 4.6).

⁴ SDQ – a national snapshot surveying the emotional wellbeing of children in care

5. 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 The area team (AT) of NHS England is increasingly developing its role in local safeguarding assurance arrangements. A safeguarding network has been established by NHS England and the area is working with the designated doctor and nurse to identify priorities to strengthen child protection work and safeguarding arrangements generally. Recent strengthening of the structure and role clarification of all designated professionals is a positive development to improve leadership capacity. The designated professionals for safeguarding have a significant role in developing a new work plan to take forward the planned improvements. The AT is represented at the local safeguarding children board (LSCB) with its expertise contributing to strengthened role awareness across all partners through its contribution of a paper to clarify health partners' responsibilities. Leadership and management structures to support effective safeguarding are in place in the main provider organisations.

5.1.2 Strong leadership and direction from the chair of the LSCB is welcomed and agencies are starting to be held to account more rigorously for safeguarding performance. Local Practitioner Forums were established by the Solihull LSCB during 2011/12 for local agency partner clinicians to attend. Health professionals in Solihull have attended these forum meetings which facilitate better networking and understanding of other agency roles and safeguarding processes for children.

5.1.3 The experienced designated safeguarding nurse provides valued support and practice advice to the CCG and to health professionals in Solihull and maintains strong links with local neighbours and the wider profession. However, there have been significant and long-standing gaps in other arrangements for leadership of safeguarding in several areas of work which the CCG and NHS England have taken action to address through welcome additional investment in capacity which was being formalised at the time of the review. The recently agreed commissioning of a named GP role will address a gap in compliance with guidance and strengthen arrangements for safeguarding leadership.

5.1.4 Commissioners have not yet looked at the role and responsibilities of GPs with looked after children or enhancing GPs skills and knowledge for effectively contributing to this work. The focus and engagement of GPs in addressing the health care needs of children who are in care and care leavers has scope for improvement (recommendation 2.2).

5.1.5 The resourcing available to assure the health of looked after children through strategic and operational arrangements has also been under significant pressure since 2012/13. This period impacted on the capacity of the designated leads to undertake their strategic roles. Despite this, the small team worked extremely hard to deliver a range of operational service improvements. Solihull CCG authorised an increase to capacity during 2013 and HEFT community services have been progressing the recruitment of a band 6 Nurse and a part time band 3 administrative support for the LAC service. The location of the designated nurse role at band 7 should be kept under review to ensure that the role has appropriate authority for the strategic leadership required (recommendation 4.1).

5.1.6 Borough health leadership is represented on the (LSCB) and sub-groups. The Designated Doctor and Nurse for Safeguarding Children are both members of the LSCB as is the Chief Nurse for Solihull Clinical Commissioning Group as Executive lead. This is to ensure that the LSCB is able to draw on appropriate expertise and advice from frontline professionals from all relevant sectors. This includes the designated doctor and nurse, the Director of Public Health, Principal Child and Family Social Worker and the voluntary and community sector. The LSCB scrutinises health partners' safeguarding activity and has focused on some key areas for audit. Each GP practice has a safeguarding lead and safeguarding networks have been established. The leadership of a named GP will provide capacity to further develop partnerships, advice, consistency of practice and quality assurance of safeguarding arrangements. Whilst there is a lot of commitment, GPs awareness and skills are not yet fully secured across the borough. The key role of GP practices in identifying families who may need help is increasingly recognised. The named GP post holder has scope to promote and ensure there are robust two way information sharing arrangements borough-wide as this is an issue which GPs identified as not yet consistent.

5.1.7 We saw some examples of families benefiting where close partnership working between health visitors and GPs is well-established, for example a new mother was well supported, which ensured she had speedy access to appropriate help. Joint working and information sharing between GPs and health visitors is not yet sufficiently robust however (recommendation 3.1). The new local requirement to increase case awareness within practices will enhance safeguarding practice but in some surgeries no current liaison was taking place. The inclusion of health visitors in regular information sharing, as in one surgery where the health visitor attended weekly practice meetings is to be commended; at another, the Dorridge surgery, arrangements are in place for formal three monthly meetings with their named health visitor.

5.1.8 The majority of GPs use an electronic records system which is accessible across community health and includes appropriate identification of children who are vulnerable in terms of child protection, child in need and looked after status. However, it is difficult in some cases to get an overview of what the current risks are and how effectively they are being managed. Some practices would benefit from improved quality assurance arrangements including the development of a programme of comprehensive auditing to provide a clearer picture of the legal status of children and the outcomes of work undertaken by health visitors, school nurses or CAMHS (recommendation 2.1).

5.1.9 The health and social care partnership works well in referring and supporting children of parents who have significant alcohol or substance misuse problems through the 'hidden harm' service to children which is an exemplar of good practice. The health professional in this council- provided service offers a range of therapeutic help as well as referrals to young carers and other services that can reduce the impact of addiction on children in the family. However, the needs of children of parents who experience mental ill health deserve greater multi-agency recognition and support than was evidenced in two cases in particular that we saw in the mental health service and which were drawn to the attention of managers (recommendation 7.2).

5.1.10 Through the use of service reviews and agreed aspirations for better outcomes, joint commissioning is starting to secure improvements in local services. Service delivery patterns and contracts are subject to a number of imminent changes. Implementation of changes to a re commissioned drug and alcohol service are well advanced. Re- commissioning of local specialist CAMH services is also in progress, but we heard a lack of knowledge about its configuration from April 2014. We understand that commissioners are taking this opportunity to address some current gaps including out of hours' services.

5.1.11 There is a significant strategic partnership commitment to developing early help approaches and services for children of all ages and their families. Solihull is a pathfinder for the Early Intervention Programme. The Solihull Children and Young People's Plan 2013-14 is supported by strong intelligence about the local population, progress and areas for improvement. Health services have a significant part to play in this agenda and the plan in particular recognises the opportunity for many more families to be benefit from early help work including the use of CAF approaches in the practice of frontline workers. Positively, CAF work is being further supported and promoted this year through performance incentives in health, but progress up to now has been unacceptably slow. Health professionals' support of children through CAF work is a priority for strengthening leadership. We would recommend further consideration to ensure that the valuable contributions of school nursing are fully recognised and reflected in strategic plans, targets and outcomes for children.

5.1.12 Local data identifies domestic violence as a significant risk to the well-being of a small but significant number of children in Solihull. Health partners' reviews following recent cases of harm to children have identified that domestic abuse was not sufficiently probed. Action from the local serious case review in respect of enhancing emergency care settings' focus on domestic abuse is still to be completed. Our review findings further reiterate the need for greater focus on recognition of the impact of domestic abuse and on ensuring on-going support for the children affected.

5.1.13 The recent local serious case review has promoted tighter scrutiny of liaison and partnership working between midwives and health visitors. We saw evidence that action has been taken to ensure both mother and baby's notes hold all relevant details about risk. ICare notes have also been audited to ensure better checks of children on child protection plans and we saw good consistency of this in the notes we read.

5.1.14 BSMHFT currently provides tier 3 and 4 specialist prescribing and treatment services for adults. Overarching leadership and governance responsibility for safeguarding across the services within the local drug and alcohol service partnership has recently been implemented. Quality assurance arrangements include service specific audits and on-going Trust audit work that is being supplemented by implementing more qualitative audit of safeguarding work. Investment in a new, enhanced IT system is contributing to more effective systems for monitoring. Currently, we found that case files comprise a mix of electronic and paper records which make it hard to get a complete picture of a case. A key priority recognised by BSMHFT and the range of addictions services is to ensure a single clinical framework is in place and effective and this will be supported by the new cohesive IT system.

5.1.15 Gaps and incompatibilities in ICT systems across health services risk delays in information being shared, which in turn may detract from effective analysis and co-ordination of multi- agency responses (Recommendation 4.13).

5.1.16 Health visiting capacity across the Borough is stretched. Caseloads in the north of the borough are especially high; recent staff turnover, vacancies and pressures impact on consistency and continuity across the Borough. Staff are working longer hours and being paid overtime to fill some gaps. The health visitor antenatal role has now been clarified and we were assured will be taken forward. There is also a Birmingham and Solihull Quality and Innovation (CQuin) target for maternity antenatal services in 2014-15. However, the effectiveness of the current health visiting service in delivering its full potential within Solihull's new draft early help strategy should be kept under close review, especially given the complexity of work in the north and health visitor practice teaching commitments in the Borough (recommendation 4.12).

5.1.17 Health visitor corporate caseloads mean that families may have different health visitors involved in their care unless concerns are identified by the time of the last baby's 8 week check. This runs the risk that relationships may not be sufficiently developed with some parents and changes in the baby's care or presentation may not be promptly identified. Working in this way requires particularly robust systems and recording practice and our case work identified some areas where further attention is needed to assure consistency of systems to safeguard children (recommendation 4.11).

5.1.18 The place of the school nursing service in contributing to improved outcomes appears to be less well clearly set out than that of other service areas' plans to improve the health and well-being of the borough's children and young people. Particularly in respect of neglect, self-harm and emotional well-being and sexual health, school nurses offer an important resource to improve outcomes. The impact of an extended period of change and capacity challenges in the school health service is evident. The service is currently prioritising work to high risk rated activity only. Whilst school nursing has been subject to restructuring and refocussing, some turbulence is to be expected. There has been a period with two teams holding corporate caseloads to manage workload. However, cumulative challenges and significant turnover have now led to current service provision through one borough wide team. This means that staff can be assigned to work anywhere rather than the local 'patch' working has an even greater impact on establishing relationships and early help interventions. We also heard concerns that the current isolated location of the north team affects efficient working as well as staff morale. Positively, we heard that the team leader post is now year round. However turnover and vacancies at team leader and practitioner level are impacting on quality assurance, development, oversight and capacity to lead CAF work. We saw evidence of the lack of continuity in relationships, vacancies and new staffing in some of case work although we also saw some good work with individual children.

5.1.19 Whilst each high school now has a named nurse, each covers 2-3 high schools which is a high case load. Drop in sessions do still take place fortnightly at schools in the south and have recently been reinstated at schools in the north but capacity there is insufficient to enable these to be as regular as planned. It is a concern that primary schools have no dedicated links or regular drop in visits despite the key role for health practitioners for some children who are at risk. Without regular links within schools, the contribution of school nursing to child protection arrangements is lessened. The profile of school nursing as part of the early help safeguarding structure for young people appears to be low, with school nurses not always being notified and involved in multi-agency early help and child in need work to support individuals. The school nurses' role in child in need processes is under developed currently. Clearer pathways, promotion of the role and strengthened and more visible links and enhanced delivery of the healthy child programme should contribute to improved effectiveness to outcomes for young people.

5.1.20 In view of the extent and length of this turbulent period, a review of the risks related to and its impact on the quality and reach of safeguarding and oversight of the health of young people across the school age range would be worthwhile. Some case work we examined indicated particular gaps in the effectiveness of support for school age children in families experiencing domestic violence. The role and capacity of the school nursing service needs further consideration in ensuring that children in households affected by domestic violence receive timely support.

5.2 Governance

5.2.1 The period since the last inspection has a high level of change in NHS commissioning and provider activities. Some staff continuity at senior and designated professional roles has been helpful in ensuring that outstanding actions from that inspection were brought into the new arrangements and an updated plan was presented to the quality and safety group of the CCG in late 2013. In addition, the CCG reported to the governing body's quality and audit sub committees the outcome of 'significant assurance' in relation to safeguarding following an internal audit undertaken by an independent body, CW Audit.

5.2.2 The CCG has continued to work in partnership with the local authority to ensure that service delivery is targeted at local needs. This is currently being supported through section 75 agreements for joint commissioning of CAMHS and children's non specialised health services. A joint commissioning board (JCB) structure has been established to strengthen governance and assurance behind these agreements and oversee the delivery of the aims and objectives. The JCB is a sub committee of the Health & Wellbeing Board to which the Early Help Board also reports. The children's plan includes aims to improve the contribution of health services to safeguarding and early help for children and families.

5.2.3 Governance of safeguarding practice has received increased scrutiny across agencies. BSMHFT is developing a strengthened governance framework for safeguarding in line with changes in the trust. The CCG Board appropriately receives annual reports on safeguarding and the health of looked after children but recognises the need for arrangements to give greater assurance and scrutiny of risks and monitoring of improvement activity. The CCG has established and is continuing to develop monitoring arrangements for safeguarding practice. The CCG governing body has recently begun to develop arrangements to ensure that appropriate reporting and monitoring will be managed at quality & safety operations group and governing body levels. The governing body is continuing to strengthen its arrangements to ensure appropriate reporting and monitoring. This is managed at the quality subcommittee of the governing body with exception reporting directly to the governing body.

5.2.4 Board members will further explore this during the planned development day in March 2014. Case work we saw demonstrates that quality assurance requires further development at individual service level and through an overall monitoring framework. There is a role for the CCG in developing its assurance capacity and challenge through greater focus on outcomes (recommendation 1.1).

5.2.5 The effectiveness of early help and safeguarding work through consistency of practice across health agencies would be enhanced by clarifying and monitoring at CCG level, clearly defined standards of expectation. With the exception of health visiting and school nursing, health agencies contribution to child protection work through the provision of reports and attendance at meetings, is also very inconsistent and routine attendance at core groups is dependent on there being specific health needs rather than to contribute expertise about child health. Quality standards should include, for instance, the required contribution and involvement of all health practitioners in child protection and child in need meetings, core groups and teams around the family where we found practice was particularly variable (recommendation 1.2).

5.2.6 The CCG is in the process of strengthening assurance through contract variations with HEFT community services with improved reporting requirements into its Quality & Safety Operations Group. In addition to the existing annual report, Solihull CCG is anticipating bi-annual reporting by exception on the key areas of service provision and participation/ experience of looked after children and young people. Both provider Trusts have safeguarding governance arrangements in place which have recently been reviewed and strengthened.

5.2.7 All agencies involved in the recent serious case review have taken the opportunity to strengthen practice. Within this work, HEFT identified the need for greater focus on identifying domestic violence in presentations at emergency care centres. This action is still to be completed pending the outcome of a business case to strengthen capacity in this area. We saw some evidence of changes starting to come into practice as a result of learning from this and serious case reviews reported from other areas.

A local serious case review in 2013 has brought tighter scrutiny by HEFT about liaison and partnership working between midwives and health visitors. Action has been taken to ensure both mother's and baby's notes hold all relevant details about risk. ICare notes have also been audited to ensure better checks of children on child protection plans. There is still further work to be done to embed some changes to liaison practice.

5.2.8 The CCG is further developing its performance monitoring data of national and locally collected indicators. Monthly quality and safeguarding reports provide oversight of safeguarding arrangements and organisational risk. As a member of provider Trusts' Boards the designated nurse for safeguarding receives monitoring reports for all services. Following the local serious case review, safeguarding assurance and compliance arrangements within contracted and sub contracted services have been reviewed and strengthened.

5.2.9 Both provider trusts produce appropriate annual reports on safeguarding across the Birmingham and Solihull areas. Annual reports include reviews of past objectives and objective setting for the forthcoming year. Child and adult addictions services are commissioned by the council and provided by a partnership of statutory and voluntary sector organisations. Safeguarding has a strong place at monthly clinical governance meetings which now provide leadership across the SIAS drug and alcohol service partnership. Progress from the joint SIAS safeguarding working group is reported into these meetings.

5.2.10 We found that systems to evidence improved health outcomes for all vulnerable children and young people require further development at team/service and wider system level. As one example using looked after children, limited work has yet been undertaken to understand the health inequalities they experience and to track the effectiveness of interventions in improving outcomes (recommendation 1.1).

5.2.11 The revised health review format is much improved and offers opportunities to think about the child/young persons' health needs in a much wider context, identifies outstanding needs that can influence health and wellbeing outcomes for this vulnerable group and guides the reviewer to set clearer health targets with identified timeframes. Practice is not yet fully robust however. Data capture about the specific health needs, disabilities and long term conditions of young people who are looked after will be enhanced if further improvement in the quality and specificity of looked after children's health plans can be achieved. (recommendation 4.3).

5.2.12 Annual looked after children health reports are prepared by the designated nurse and doctor and presented to the CCG, provider board and corporate parenting board of the council. They provide a clear outline of planned actions to improve the quality of local arrangements. Audit is used to good effect to identify themes and improvement areas and we were able to see changes as a result of this work.

5.2.13 Quality assurance of children's health assessments and individual health plans has started to be addressed but this work has been severely limited by capacity within the team and the demands of day to day work to undertake assessments and reviews. Our review indicates there are a few areas for further challenge including ensuring all health plans are holistic and that emotional well-being and the impact of neglect and trauma is recognised and addressed at an early stage (recommendation 4.2).

5.2.14 We saw examples of an increased focus on audit in most services and in some cases we were able to see changes implemented and re-audited to ensure change is embedded. However, further work is required to embed learning and support cultural changes to strengthen health's contribution in building parenting capacity and reducing risk to vulnerable adolescents. Auditing of the work of school nurses, in particular, is at a relatively early stage of development in that a target to audit 10% of casework has recently been identified. It will be important to ensure that well targeted regular audit and review is achieved given the risks arising from service capacity and the alterations to role and expectations.

5.2.15 Sexual health clinics are provided by HEFT staff and appear to be well used by young people. The development of auditing and the monitoring of take up would help to evaluate the extent to which these services are accessible to the diversity of citizens of the Borough.

5.2.16 We saw some positive examples of young people's involvement and feedback about a range of services, including sexual health and STR8up drug and alcohol service. A survey of secondary school age children contributed valuable information about the reach and profile of school nursing but there is room for improvement in other service areas such as maternity to support regular feedback and learning from young people and vulnerable parents using local health services. HEFT recognises that there is work to be done to strengthen the voice of children who attend emergency departments.

5.3 Training and Supervision

5.3.1 All providers are demonstrating increased focus on ensuring staff are appropriately skilled to safeguard children. We heard about effective twice yearly multi-agency LCSB training opportunities with good take-up, which complement internal training provided by the individual NHS Trusts. Most people we met have received safeguarding children training at the level appropriate to their roles.

5.3.2 Frontline staff valued the support they receive from named safeguarding professionals via supervision, quality assurance of reports to court etc. Overall the performance in respect of staff supervision is improving, but not yet in place across all health services. Safeguarding supervision/peer review is not embedded in all relevant areas including community midwives, CAMHS, adult mental health CASH and GPs. In CAMHS, although there is a strong clinical framework which includes consideration of safeguarding, dedicated safeguarding supervision was not in evidence at all but a framework is being implemented from April 2014. It is acknowledged that safeguarding supervision arrangements for midwifery services require further attention given the complexity of risks with which midwives are working. Capacity is being increased to support the introduction of initial supervision arrangements but preparations are not yet in place to enable an imminent roll out (recommendation 6.4).

5.3.3 Most practitioners across services have good access to ad hoc advice and guidance. This is not however, sufficient to ensure staff are fully supported and equipped in line with statutory guidance relating to safeguarding.

Recommendations

1. Solihull CCG should:

- 1.1 Develop its assurance capacity and challenge through greater focus on the experiences and impact of local health services in delivering improved outcomes for vulnerable children and for young people who are looked after.
- 1.2 Improve the effectiveness and consistency of safeguarding practice through securing key quality standards for health professionals' engagement in safeguarding, child in need and child protection and including EHMAP involvement and agreed reporting arrangements into the Solihull CCG governance structures.
- 1.3 Develop arrangements to identify barriers to children receiving timely help including access to early help, CAMHS, learning disability nursing support, specialist assessment and treatment and establish reporting into the Solihull CCG governance structures.
- 1.4 Review the commissioning of paediatric speech and language therapies and their effectiveness to ensure that children requiring early help and those who have specialist needs have access to timely, child centred assessment and treatment.
- 1.5 Review arrangements to ensure that young people experiencing emotional distress or mental ill health have timely access to specialist assessment including out of core hours.

2. Solihull CCG and NHS England should:

- 2.1 Establish quality assurance arrangements for GP safeguarding work, including the development of a programme of comprehensive auditing to assist GPs to ensure their records are clear and up to date in respect of the legal status of children and the outcomes of work undertaken by other professionals
- 2.2 Strengthen the focus and engagement of GPs and practice nurses in addressing the health care needs of children who are in care and care leavers.
- 2.3 Review the arrangements and expectations for GPs contribution to child protection work and ensure that wherever possible, barriers are addressed to support their increased engagement.

3. Solihull CCG, NHS England and HEFT should:

- 3.1 Clarify local systems for GPs and other community health staff to regularly and robustly share information about children and families where risks are identified.
- 3.2 Ensure that all community health professionals who work with children and their families have awareness commensurate with their roles, of the impact and risks of parental alcohol or substance misuse or domestic violence, this is reflected in training packages and outcomes and staff take account of this in their support for these children and that this is monitored regularly and reported into the Solihull CCG governance structures.
- 3.3 Jointly review IT systems, the use of technology and barriers that impact on timely information sharing, effective identification of risks and improved performance monitoring.
- 3.4 Ensure that training appropriately equips all health staff for their roles in improving the health outcomes of looked after children and care leavers and that arrangements assess competence and evaluate the impact of training.

4. Solihull CCG and HEFT should:

- 4.1 The location of the designated nurse role at band 7 should be kept under review to ensure that the role has appropriate authority for the strategic leadership required
- 4.2 Ensure the emotional wellbeing and mental health of looked after children is fully addressed in health care assessments, reviews and health plans.
- 4.3 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews which are all supported by SMART health plans that ensure these needs are met.
- 4.4 Implement holistic health history summaries and information about taking responsibility for their health, for all young people leaving care and ensure this is meaningful and responsive to their individual wishes and needs.
- 4.5 Review safeguarding arrangements and gaps to improve the identification and support for vulnerable young people aged 16-19 and care leavers who attend emergency departments so that they receive appropriate timely help.

- 4.6 Review the self-harming pathway and services that are available to ensure a comprehensive response to children and young people who make repeat presentations and an appropriate range of services to ensure they receive early help
- 4.7 Have systems in place to monitor and review that emergency department staff are consistent in checking and recording that they have checked if a child or young person attending is on a child protection plan.
- 4.8 Ensure that where relevant and appropriate, young people attending emergency care departments have the opportunity to be seen alone, and that their comments are consistently recorded within the assessment process
- 4.9 Ensure that hospital discharge summaries provide comprehensive information about risks and are shared with appropriate professionals in timely manner.
- 4.10 Ensure that where vulnerability is identified in a pregnant woman, a clear pathway is put in place to identify and manage risks to all children in the family.
- 4.11 Ensure that systems are in place for regular checks of practitioners' recording practice across health services
- 4.12 Review the effectiveness of the health visiting service in delivering its full potential within the early help strategy and commensurate with the needs of the borough and practice teaching commitments
- 4.13 Arrangements should be reviewed to identify and address any barriers to effective information sharing including IT incompatibility, between hospitals, and GPs and other community health staff.
- 4.14 Review arrangements for ensuring that parents with learning disabilities receive appropriate information and support to prepare for parenthood.
- 4.15 Review arrangements for paediatric liaison, including capacity, to ensure that robust arrangements are in place across all acute care settings so that risks to all Solihull children and young people are effectively identified and followed up.

5. Solihull CCG, NHS England, HEFT, BSMHFT and Birmingham Cross City CCG should:

- 5.1 Ensure that children in need and others requiring early help or step down support receive the help they need through the contribution of health professionals with clearly identified roles and regular reviews of progress and outcomes.

- 5.2 Clarify accountabilities and review systems and opportunities for improved information sharing with the home area where there are increasing risks and about how related health needs are being addressed for children who attend schools out of borough.
- 5.3 Ensure that robust arrangements for communication, liaison and systems of recording between midwifery, mental health, drug and alcohol services, health visiting and school nursing effectively safeguard vulnerable children and families.

6. Solihull CCG, HEFT, BSMHFT and Birmingham Cross City CCG should:

- 6.1 Ensure that safeguarding referrals clearly set out risks and impact on children and that robust arrangements are put in place to assure the quality of health professionals work in respect of safeguarding referrals and children in need and child protection work to ensure that children for whom risks are identified receive prompt holistic support.
- 6.2 Ensure so far as possible that staff across all health disciplines including CAMHS, adult mental health, drug and alcohol services and sexual health services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.
- 6.3 Promote increased understanding across the Partnership about the role of all health professionals to maximise their engagement and inclusion in child protection and children in need arrangements and planning, encourage improved risk assessment, young person's engagement with services, and the timeliness of early help.
- 6.4 Ensure regular and effective supervision arrangements in line with inter-collegiate professional requirements are in place for all staff who are involved in safeguarding and child protection work and that this is monitored by the providers and reported into the CCGs.
- 6.5 Review current cases involving both maternity and adult mental health services where there are children within the family to ensure that the well-being of all children is taken into account in risk assessments, safeguarding and liaison with other services.
- 6.6 Tighten awareness and practice relating to establishing the details of all adults in a household and their relationships to the child and each other.
- 6.7 Review practice and guidance to ensure that all professionals working with vulnerable families fully understand and reflect Think Family within their initial assessments and ongoing work with families affected by domestic violence, parental mental health or substance misuse.

7. In conjunction with Birmingham Cross City CCG, Solihull CCG and BSMHFT should:

- 7.1 Ensure that perinatal and adult mental health practice is consistent in recognising the needs and risks to all children within families who are affected by mental illness and working with partners to safeguard these children
- 7.2 Ensure there are systems in place to monitor and review that the needs of children of parents who experience mental ill health receive recognition and support including consistent referral to young carers and to other relevant agencies and findings are reported into Solihull CCG governance structures.

Next steps

An action plan addressing the above recommendations is required from the CCG within 20 working days of receipt of the finalised 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 team.