

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

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

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## Summary of the review

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

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

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## About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 100 children and young people.

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## Context of the review

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The majority of Gloucestershire residents (97%, 600,577 residents) are registered with GP practices that are members of the Gloucestershire Clinical Commissioning Group. Slightly under a quarter (23%) of Gloucestershire's population is under the age of twenty. 11% of school children are from a black or minority ethnic group.

The health and wellbeing of children in Gloucestershire is generally better than the England average, with only two out of 32 health indicators used to assess health and wellbeing being significantly worse than the England average. One significantly worse indicator was the rate of hospital admissions as a result of self-harm. The other significantly worse indicator was the percentage of children in care with up to date immunisations, despite Gloucestershire having a lower rate of children in care when compared to the England average. However, overall the percentage of children having MMR immunisations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared with the England average.

The infant mortality rate was better than the England average and the child mortality rate was similar to the national picture. In terms of hospital admissions, the rate of A&E attendances for children under four years of age, the rate of hospital admissions due to injury for under 18 year olds and the rate of hospital admissions for mental health conditions were significantly better than the England average.

The conception rate for under 18 year olds per 1000 females in Gloucestershire and the percentage of teenage mothers in the area was significantly better than the England average. Breastfeeding indicators including breastfeeding initiation and breastfeeding at 6-8 weeks were also significantly better than the England average.

Strengths and difficulties questionnaires (SDQ) are used to assess the emotional and behavioural health of looked after children within Gloucestershire. The average score per child in 2013 was 14. This score is just on the cusp of what is considered borderline cause for concern. The average score per child has shown a slight decrease (previous score was 15) in 2011 and 2012.

In 2013 Gloucestershire had 320 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). 86% of these children had their immunisations up to date. 83% received their annual health assessment and 69% of LAC had their teeth checked by a dentist. As at 31 March 2013, there were 60 looked after children who were aged five or younger, 58% of these children had up to date development assessments.

Gloucestershire Care Services NHS trust was established on 1 April 2013 and provides a range of services to approximately 600,000 people across Gloucestershire including adults, children and young people. The services provided by the trust include community inpatient and outpatient services, public health nursing, community nursing and therapy staff. The trust's services are mainly commissioned by Gloucestershire Clinical Commissioning Group and Gloucestershire County Council.

The Gloucestershire Hospitals NHS Foundation trust is a large hospital trust providing acute elective and specialist care for a population of more than 612,000 people. The trust was formed in 2002, with the merger of Gloucestershire Royal and East Gloucestershire NHS trusts and runs both Cheltenham General and Gloucestershire Royal Hospitals. The trust's doctors and nurses also see patients at clinics in all of the smaller hospitals across the county.

2gether NHS Foundation trust provides mental health services to the population of Gloucestershire, Herefordshire and the surrounding region. The trust provides specialist emotional wellbeing and mental health service for all children and young people (up to the age of 18) who are registered with a GP in Gloucestershire. The service used to be called 2gether CAMHS but since April 2011 the service was renamed to reflect changes to the way that the service was delivering its services and in response to feedback from children and young people who used the service. The children's service is now called 2gether Children and Young People Service (CYPS).

Commissioning and planning of most health services for children are co-ordinated by the Joint Commissioner for Gloucestershire County Council and Gloucestershire Clinical Commissioning Group (CCG).

Commissioning arrangements for looked-after children's health are the responsibility of Gloucestershire CCG. The children in care health team, designated roles and operational nurse for children in care are provided by Gloucestershire Care Services NHS Trust. Initial health assessments are contracted to a GP practice, Hadwen Medical group.

Acute hospital and Community midwifery services are provided by Gloucestershire Hospitals NHS Foundation Trust

School nurse services are commissioned by Gloucestershire County Council and provided by Gloucestershire Care Services NHS Trust.

Contraception and sexual health services (CASH) are commissioned by Gloucestershire County Council and provided by Gloucestershire Care Services NHS Trust.

Child substance misuse services are commissioned by Gloucestershire County Council and provided by Gloucestershire Youth Support Service (provided by Prospects Services Ltd).

Adult substance misuse services are commissioned by Gloucestershire County Council and provided by Turning Point.

Child and Adolescent Mental Health Services (CAMHS) known as CYPS are provided by 2gether NHS Foundation Trust.

Adult mental health services are provided by 2gether NHS Foundation Trust.

Gloucestershire underwent a joint CQC and Ofsted safeguarding and looked after children ([SLAC](#)) inspection in December 2010. At the time the 'overall effectiveness of the safeguarding services' outcome was assessed as 'inadequate' and the 'overall effectiveness of services for looked after children and young people' outcome was assessed to be 'adequate'. Recommendations from that inspection are covered in this review.

At the time five recommendations were made:

- Ensure appropriately trained individuals undertake health assessments and implement a robust monitoring system to ensure consistently good quality of health assessments for looked after children and young people who are living in placements either in or out of county.
- Ensure that there are sufficient resources within the child and adolescent mental health service to meet the mental health needs of looked after children and young people.
- Ensure care leavers receive good quality health information, advice and guidance and are provided with a full summary of their healthcare history in a format suitable to their needs.
- Gloucestershire Hospitals NHS Foundation Trust to ensure targets for level 1 safeguarding training are achieved and compliance maintained.
- NHS Gloucestershire to develop and implement robust monitoring systems for the safeguarding responsibilities of all independent contractors.

These recommendations are covered in the report.

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## The report

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

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## What people told us

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A parent of a child waiting in the Emergency Department told us her child had;

*"been seen quickly and we were offered to wait in a children's only waiting area. The staff were helpful and we are happy with the service"*

Foster carer's told us:

*"I think it is better now that the GP who does the IHA phones me as the foster carer when they have got the paperwork through and lets me make the appointment at my convenience."*

*"I asked lots of questions about the medication policy. The looked-after child nurse suggested I help rewrite it. I spoke to other foster carers and we all worked on it. The policy was rewritten and is easier to understand and to follow. Quite a result"*

*"The training courses on health have been very good. The one on everyday health by the looked-after child nurse was the best one I have ever been on."*

*"You don't get a lot of history on the child, full stop, health or social. We have challenged this before"*

*"Health visitors are very good and visit the mother and baby we foster every week. They are very thorough and easy to contact when I need advice"*

*"The IHA we had with a male GP was so good. He gave the assessment lots of time and was very thorough. As the foster carer, he saw me separately for a few minutes and saw the Mum separately. He was very good with the baby."*

Care leavers told us;

*"The Social worker referred me to mental health and substance misuse; they helped me get off drugs, been clear for 6 months now. They reassured me that I could do it. I can't go back to them now as I'm 18, but I can go to Turning Point if needed –they offered to transfer me to Turning Point but I knew that I didn't need it then, I want to use will power. I know that the future will be good, it's boring doing drugs, you lose your family and friends; it's a dark place to be. I shouldn't have gone into supported living; it put me in contact with drug users at 16."*

*"There was no plan for leaving care, no meeting; I'd like a health history."*

GP's told us;

*"The GSCB multi-agency level 3 safeguarding training was the best safeguarding training I have ever done"*

*"The GSCB training is fantastic. Lots of case examples and lots of health visitors, police and other services but no other GPs except me!"*

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## The child's journey

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

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### 1. Early help

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1.1 Vulnerable children and families in Gloucestershire have access to a good and increasing range of health and social care led early help services which are effective in delivering positive outcomes. Examples of this include the Turning Point Substance Misuse parenting group which delivers seven sessions covering parenting, healthy eating, play/ interaction skills and behaviour management; Secure Start, a service focused on attachment issues for parents and young children, and the "Turn Around for Children" programme for children who are experiencing or are at risk of chronic neglect due to a combination of substance misuse, poor mental health and/or domestic abuse. However in some service areas, expansion of early help is limited by capacity pressures and uptake is affected by staff awareness of availability. This means some parents who require additional support are not accessing the services they need.

1.2 The midwifery process, which includes a pre booking appointment by phone and then a home booking in appointment, is effective in engaging mums- to-be at an early stage. This enables practitioners to make an assessment of home conditions, potential risk or additional support needed by the 12 week stage. Midwives are routinely prompted in their booking in paperwork to consider both the father of the baby and/or current partner in terms of mental health, substance misuse and domestic violence and this is a positive development. Good examples of practitioner liaison between disciplines and inter agency working is bridging the gap that exists in formalised information sharing, due to the absence of formal multi-agency safeguarding maternity liaison meetings. Although there are regular locality multi-agency meetings, co-ordinated by Turning Point Substance Misuse service, which midwives attend and report as very useful in sharing intelligence about vulnerable children and families, there are no maternity liaison meetings which involve children's social care in discussions about unborns and pregnant women where there are concerns. Individual cases may be discussed at specially convened meetings on a case by case basis (recommendation 2.2).

1.3 The midwifery service has not been routinely integrating ante and post natal records into the new baby's record in line with best practice and as a result there is a risk that key information about pre-birth concerns may be lost. This issue has been identified as an area for development by the midwifery operational group and a new proforma is to be introduced imminently to ensure the integration of the records.

1.4 There is a perinatal mental health protocol in place but some staff spoken to were unaware of it, leading to inconsistent positive impact and outcomes being seen.

1.5 There are a range of specialist midwifery practitioners to support vulnerable pregnant women, both through direct case work and by the provision of additional advice, monitoring and input to the community midwives. Midwives value this support and feel that it works effectively to provide a network to vulnerable mothers. There are challenges for young people from the Cheltenham area accessing the teen pregnancy midwife services as they are based at Gloucester Royal Hospital and this can be difficult for young people to physically get to. Whilst midwives report that, in these cases, they work jointly with the teen pregnancy team to deliver a service locally, it means that access to a valued service is inequitable (recommendation 2.3).

1.6 There is good multi-agency commitment to improve information sharing and work co-operatively to provide early help support to children and families. The new partnership meetings involving midwives, health visitors and children's centre workers in localities are indicative of this and are helping to raise practitioners' understanding of resources and services available in a locality. This is improving practitioners' ability to signpost expectant and new parents with support needs to appropriate services.

**Case example:** *We heard about a care leaver who needed additional support in the latter stages of her pregnancy. The community midwife had a supportive role sourcing food bank vouchers and baby equipment via a local charity to ensure the new-born baby's practical needs were met and the parents were introduced to the local services they could access for practical support on an ongoing basis.*

1.7 Joint working between midwives and health visitors is not consistent at present. The impact of the Call to Action programme that aims to increase the numbers of local health visitors is starting to build the capacity of the frontline health visiting teams, however further work is required to ensure effective communication and handover arrangements between health visitors and midwives. The re-introduction of monthly practice meetings involving health visitors, midwives and GP practice staff is encouraging although attendance by health visitors in some areas is not yet routine. We saw some good examples of a health visitor identifying concerns about the health and wellbeing of a child, and promptly taking her concerns to the safeguarding lead in the service and seeking supervision to determine how best to progress the case. Another positive example was that of a highly vulnerable baby and family benefitting from early help which led to increased parenting capacity, and a strong attachment developing between baby and parents. The case is now closed to children's social care but the family continue to do well supported by common assessment framework (CAF) provision through the health visitor and children's centre.

1.8 Health visitors have told us that they find it hard to secure good liaison with adult mental health workers and in one case example seen, adult mental health have not been invited to participate in the CAF although they are working with the parent. This led to incomplete information being shared with all the professionals involved and opportunities for the family to access support were reduced (recommendation 3.3).

1.9 A Turn Around for Children service that provides an intensive support model is a positive mechanism to provide enhanced input to families that are vulnerable and shows consideration of developmental needs of the child including speech and language and developmental milestones. However, the availability and staff awareness of this service is inconsistent. We identified cases throughout this review where families clearly fell within the criteria but this option had not been considered or explored by the relevant workers involved with the family. This was a missed opportunity for families to access the service (recommendation 1.8).

1.10 School nurses were able to identify a range of early help services that they had used and found helpful, although they experience challenges in keeping up to date with service changes that occur frequently due to changing funding arrangements. Particular value was placed on the advisory line provided by 2gether children and young people mental health service (CYPS) and practitioners had found that it was effective in supporting their work. However, a strong perception remains among staff across health services that access to CYPS therapeutic services is challenging with high thresholds and long wait times. The implementation of the choice appointment is ensuring most children and young people are being seen for an initial triage appointment within four weeks however there can still be a delay in starting treatment for some children.

1.11 Aside from a practice nurse in Dursley who runs a young person sexual health clinic weekly at a GP surgery and a lunchtime clinic at the local school in an outlying community, the young persons' offer from the integrated sexual health service (ISH) is low. The drop-in service is accessed by many young people who would otherwise be unlikely to travel to Gloucester to access ISH. The complexity of the geography of the county poses a challenge to services in terms of equality and consistency in service provision/access; however the location of one clinic in central Gloucester is not particularly accessible for young people. Drop in clinics running in the further education colleges and those provided by school nurses are well used, however there are currently no joint clinics with youth services, youth offending team or young person substance misuse teams. Sexual health care and treatment services targeting young people are under-developed. Young people are not a highly visible presence in this service and there is a lack of innovation in how to reach young people to maximise the impact and uptake of sexual health services.

1.12 The integrated sexual health service (ISH) has clear risk assessment documentation relating to young people who attend aged under 16, and examples seen showed that these are completed to a high standard, underpinned by detailed and thoughtful history taking by health advisors. Cases seen also indicated that health advisors are active in following up issues with school nurses or other health and social care professionals as appropriate. This is good practice and ensures prompt support to young people. However, there is a gap in that risk assessment forms do not include young people up to age 18 and therefore risk assessments are not routinely carried out on 16-18 year olds. This could lead to missed opportunities in the identification of safeguarding issues for this vulnerable group.

1.13 The availability of minor injury unit's (MIU's) across the county, including some with 24 hour access has had a positive impact on reducing the acute attendances at ED. However it is noted that at present some of these MIU's are underutilised. There are clear benefits of local availability and knowledge that is provided by these, particularly in terms of their ability to liaise closely with GP practices however, there is an inherent risk of inconsistency and inequality in access to services across the county as each local MIU operates differently from the ED. Pathways such as automatic referral to the young people substance misuse service that are in place at ED are not yet set up for MIU's (see recommendation 1.4). We also found a decreased level of awareness and activity in the paediatric liaison health visitor (PLHV) role in certain areas of the county despite the role being very high profile in ED at Gloucester Royal Hospital. We encountered significant staff confusion across a range of areas of how notifications and referrals to PLHV were progressed (recommendation 1.1).

1.14 Some examples of good safeguarding risk assessment were seen in ED at Gloucester Royal Hospital with effective identification of vulnerabilities for the child and/or the family and appropriate referral for community follow up. However, several other cases seen at both EDs and some of the MIU's demonstrated that practice in safeguarding risk assessment is patchy. There was insufficient probing by staff for full information and a lack of effective monitoring to ensure that all safeguarding issues are identified and acted upon appropriately. When referrals of children attending ED and MIU services are made to the paediatric liaison health visitor, there is good communication and follow up of risk to children into community health services. However, not all necessary written referrals to the paediatric liaison health visitor or to children's social care are being made, and in some cases practitioners had a verbal discussion with the PLHV which was not documented. Without effective monitoring that all safeguarding issues have been identified at the point of the child's attendance there is a risk that some young people will not be safe when discharged (recommendation 1.2).

1.15 The triage documentation at both Emergency Departments for both adults and children has fields to record who is accompanying the patient and these are routinely completed. However, there were some cases at MIU Cirencester where there was not further probing of this information and a lack of professional curiosity about the exact relationship the accompanying adult had with the child when the person was not the child's parent. The safeguarding risk assessment on the front of the ED documentation at Gloucester Hospitals Foundation Trust is good practice and includes prompts for staff to give consideration to the demeanour of patients and interaction between adult and child. However, this risk assessment is not routinely completed and we saw a number of cases both at ED and the MIU where the assessment had not been completed or only partially completed. This reduces the effectiveness of the risk assessment and increases the risk that staff may not fully consider safeguarding issues (recommendation 2.4).

1.16 There was low awareness of early help options among adult mental health (AMH) leads. A perception by adult mental health staff that early help referrals should be led by social care could lead to missed opportunities to secure good support to families in need of early help. In one case that we saw, AMH practitioners had been persistent in their efforts to engage a parent with mental health problems, and felt that a referral to social care services would have been ineffective if not detrimental to the care planning for them. However, the lack of "think family" approach in this case resulted in missed opportunities for assessment of the needs of the children in the family, who are likely to be affected by the parent's continuing attempts at self-harm (recommendation 3.2).

1.17 We saw examples of children benefiting from the therapeutic interventions of the CYPS service leading to good outcomes. CYPS is also developing lower level support for young people with mental health issues. This includes the provision of some online treatments available through the increasing access to psychological therapies programme (IAPT) and voluntary sector provision from Action for Children and Teens in Crisis who support children at home and at school. Positive feedback has been received by the Tier 2 mental health advice phone service for practitioners working with young people with mental health issues from some GP's, school nurses and social workers which allows greater and more rapid access to mental health support.

1.18 Children and young people aged up to 16 attending both GRH and CGH emergency departments with mental health issues have good access to CYPS assessment which is routinely available at weekends. Waiting times have been reduced. The introduction by CYPS of the practitioners' advice line and foster carer drop in sessions to discuss CAMH issues is also a highly positive development to improve outcomes for children and young people, including children in care (CIC).

1.19 The young people's substance misuse service (YPSMS) is highly flexible in its approach to engage young people with substance misuse issues and we saw very positive outcomes. Assessments are comprehensive and information is shared effectively to ensure the young person's rapid access to appropriate services. The location of YPSMS within a larger youth support team (YST) is mutually beneficial. In one case we saw rapid actions taken where child sexual exploitation (CSE) concerns were raised and a forward thinking approach to initiating police involvement using the resources available to the YST. A pathway for referrals from ED is in place if young people present with alcohol or drug related admissions; however awareness of this with both ED and MIU staff is limited and, it is not yet used on a routine basis (recommendations 1.4 and 2.8).

1.20 All services visited have robust policies to address children's non-attendance at appointments (DNA) and all health practitioners demonstrate an assertive and persistent approach to ensure the continued engagement of both children and adults with services. Services including YPSMS will extend their involvement with a young person beyond the usual age range if that is to the benefit of the young person. This commitment to the wellbeing of often very challenging young people is commendable.

**Case example:** *We saw a case where good individualised support was being given to a teenage mum to be with mental health needs involving the CAMHS psychiatrist, teenage pregnancy midwife, specialist obstetrician and substance misuse service. The risks due to past history for the young woman were recognised early and supportive intervention put in place ensuring this young woman is regularly accessing all the support she needs at present.*

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## 2. Children in need

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2.1 We saw examples of positive practice where health professionals were working closely to provide targeted support to families to prevent risks escalating and to strengthen parenting capacity.

**Case example:** *Parents with a 12 month old baby in a volatile relationship with a history of domestic violence. Mother had also had issues of poor mental health and father known to have committed drugs offences. Concerns were raised by the midwife and children's social care were involved early along with targeted ante natal contact by the health visitor who also attended pre-birth planning meetings.*

*Primary mental health care was provided for the mother although her engagement was poor initially and she did not attend early CAF meetings.*

*The Secure start service engaged well with the family and over time the support given to the family resulted in positive outcomes. The parents are now strongly attached to baby and the baby is doing well. The parents are also now well engaged with the health visitor and children's centre and the case is now closed to children's social care with the family continuing to be well supported by health professionals.*

2.2 There has been an increasing number of admissions of young people to adult mental health wards (ten since May 2013). The 2gether Trust have worked hard with partner agencies to put in place a robust, effective and stringently monitored framework when a young person is admitted to an adult mental health ward. This includes multi-agency discussion prior to the admission, and multi-disciplinary health input during the admission with policies to ensure high levels of nursing input and consideration of age related needs such as education and activities. The Trust is able to demonstrate a high level of good practice in the care and treatment of young people placed on adult wards and this was reflected in a recent inspection by CQC. Informal feedback from young people who have used the service and their families has been positive although there has been no formal evaluation of their experiences. Work is ongoing to carry out further analysis and solution focussed work around the reasons why young people's admissions to adult mental health wards have increased.

2.3 There are clear sections in the electronic assessments form used by the 2gether Trust for the identification of risk to any children and young people that an adult client using mental health services may be in contact with. However, the assessment focuses on child protection issues and this creates the potential of missed opportunities for a wider *Think Family* approach, to identify early help needs rather than focusing on safeguarding only.

2.4 Practitioners demonstrated awareness of the need to assess the impact of parental mental health on young people. One case had good reference to the needs of the young person (including their needs as a young carer). However, this is not routinely completed or approached in a formal way that is documented and formally recorded in assessments /care plans (recommendation 3.7).

**Case example:** *We saw strong liaison between a substance misuse worker and midwife when a client's drug use dramatically escalated in the last few weeks of pregnancy. After the substance misuse worker raised her concerns in the monthly team meeting safeguarding slot, a rapid CSC referral was put in for the unborn and strong liaison and communication was seen between Turning Point staff, Midwife and the community health visitor. Ongoing liaison and follow up of signs of relapse were clearly actioned with a SMART plan put in place. The Substance Misuse worker was involved in the pre-birth plan for the unborn and has attended fortnightly meetings to review the plan.*

2.5 Staff at the Turning Point service for adults misusing substances undertake home visits and prioritise these where there are children in the household on Child in Need (CIN) and child protection plans. A strong "Think Family" approach was observed and the introduction of a parenting programme for clients is a very positive offer. The service is effective in identifying children with whom the service user has regular contact and in identifying potential risks to their health and well-being. Visits are undertaken jointly with health visitors and other services where any concerns are identified. The service is building positive relationships with other services as part of the developing early help offer and community capacity building. We were told about an effective team around the child in a complex family situation where all family members were highly vulnerable to harm. The unique contribution of the Turning Point worker in highlighting the mother's health needs and specific circumstances in relation to potential for relapse, ensured the child was not placed at risk by a step down from child protection plan to CIN as planned.

2.6 CYPS are sensitive to the increased needs of young people who are placed in Tier 4 provision at a distance from their homes. Young people requiring in-patient mental health provision are likely to be placed at a significant distance from Gloucester due to capacity issues at the nearest centres. As a result, their in-patient stays are becoming longer due to the impact of being distant from family and community and the inability of the local mental health team to provide support. Although CYPS work hard to ensure good liaison with external Tier 4 providers, young peoples' transition back into Gloucester is not always seamless due to variable communication from external providers. This makes it difficult for CYPS to co-ordinate support with children's social care promptly and we heard some case examples where this had resulted in less than optimum experiences for young people. There is currently a high demand on inpatient services for children and young people from the Gloucestershire area evidenced by the increased numbers of admissions to adult wards and the effect of growing numbers of deliberate self-harm being seen in the county (recommendation 4.1).

2.7 There is not a dedicated CYPS crisis team however the “3.5 team” which is an intensive delivery model for the Tier 3 service, can provide a range of interventions to young people who are in crisis. They provide a significant level of support over the phone but currently their focus is on supporting the high numbers of young people who are self-harming, which limits their capacity to respond to young people in crisis. This is reducing the 3.5 teams’ ability to provide high intensity support to a wider cohort of young people with high levels of need who may be at risk of needing in-patient care. There is limited out of office hours access to the 3.5 team support. The service is available until 8pm and for a few hours over weekends (recommendation 3.5).

2.8 The roll-out of a national programme to all secondary schools, “Chelsea’s choice”, to raise awareness of healthy relationships and potential sexual exploitation has generally been well-received and well-regarded in the area. However, there are concerns relating to the care taken to ensure the well-being of young people who may have experienced abuse who see this school based production without sufficient preparation or support. In one case, this had traumatic consequences for a young person and led to an incident of self-harm. There is potential for young people who are not known to have been abused to experience a negative impact unless greater consideration is given to the delivery of the programme.

2.9 We saw an example of detailed assessment of a young person attending the ISH service for termination of pregnancy (TOP). The young person was referred to another unit for the procedure and there was no evidence of follow up of the young person’s well-being following the TOP. The ISH service does not actively offer young people post-TOP counselling or ensure that they are offered this by other agencies that may be more appropriate to the young person’s needs.

2.10 There is a comprehensive and well-established Sexual Assault and Referral Centre (SARC) service that ensures that young people receive a timely and effective response, including the capacity to undertake examinations at other locations where appropriate.

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### 3. Child protection

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3.1 Health visitors and midwives are not always liaising as cohesively as they should in order to ensure co-ordinated and the most effective support to families. Partnership working between health visitors and midwives is not secured by clear and jointly owned safeguarding children arrangements, leading to potential gaps in information exchange and lack of comprehensive planning and health input for this vulnerable group.

3.2 We saw a case example in midwifery whereby effective multi-agency child protection work resulted in very positive parenting changes, this enabled the children to return to mother's care and no longer be subject to any child protection or CIN plan. We also saw evidence of a specialist midwife liaising effectively with midwives in other areas to convey concerns about families moving out of area where unborn or new born babies were at high risk.

**Case example:** *A pregnant mother with several children and a history of substance misuse and chaotic lifestyle moved into the area having fled a violent relationship. Professional concerns were very high and a child protection plan was put in place for the unborn child. There was a likelihood that the child would be taken into care at birth. However, the mother began to engage with the drugs service, children's centre and early help support and there was a multi-agency decision to support the mother and baby together. Both went into a mother and baby unit which facilitated the mother's bonding with her new baby and promoted positive parenting.*

*As a result of good multi-agency working to support the family, the mother is drugs free and is providing good care to the baby who is thriving and no longer subject to any child protection or Child in Need plan. The mother is also now a breast feeding peer mentor at the children's centre.*

3.3 Pre-birth protocols are effective and communication around child protection plans for unborn children is robust. Maternity staff are aware of child protection plan details when the mother presents at the delivery suite. There is a good system for discharge plans to be held in a folder at the birth unit and so is accessible to all staff who may need to see it.

3.4 Health visitors routinely attend strategy meetings, contributing significantly to effective decision making about the support most likely to protect and result in good outcomes for the child. We saw cases where health visitors are successfully sustaining positive relationships with parents while being an effective part of the child protection process.

3.5 The specialist midwife for safeguarding and operational named midwife identified the quality of midwives' safeguarding referrals as being an area for development due to the poor articulation of the risks of harm to the baby. They have been proactive in delivering training on what constitutes good quality referrals. This is still a work in progress as quality continues to be variable and effective on-going quality assurance and monitoring is underdeveloped, as copies of referrals are not routinely being sent to the specialist midwife. Similar issues around quality of referral and clear articulation of risk were identified in the work of the MIUs we visited.

3.6 One MIU case seen involving deliberate self-harm (DSH) demonstrated that the young person was not offered admission or timely assessment in line with the trust's policy on DSH. The young person left the MIU before treatment and no immediate follow up was put in place. Fortunately, the young person then returned to the MIU after 2 days to attend an appointment and access treatment of his own volition which positively indicated that he was safe and well. The lack of an effective reviewing function for all under 18 presentations at ED and MIU resulted in this young person not being actively followed up, meaning that his safety and wellbeing was compromised (recommendations 1.1 and 2.10).

3.7 Effective processes are in place to ensure that the acute hospital electronic information system flags medical alerts regarding children who have been made subject to child protection plans, become looked-after children or are living in families where domestic violence has been identified. This supports staff's safeguarding risk assessment in the acute setting. The use of a common IT system across ED and MIU's is highly beneficial in tracking children and young people's attendance at various units across the county and acts as a further safety net and flag for clinicians. The availability of information on line and the role of a duty liaison nurse who interprets and reports on more detailed information once a flag alert has been noted also acts as a positive support role for less experienced staff. It provides an opportunity for staff to discuss issues of concern with a more senior practitioner and ensures details are appropriately recorded and actioned in order to help keep children safe.

3.8 There is good awareness of domestic violence issues in the Gloucester Royal Emergency Department. This is promoted by the practice development and domestic violence lead practitioner who routinely attends multi-agency risk assessment conference (MARAC) and ensures that any children or adult known to live in a household where there are issues of domestic violence is flagged on the trust's information system. This alerts any practitioner across the trust's and MIU sites. The use of the Domestic Abuse Stalking & Harassment (DASH) assessment model and documentation facilitates effective information sharing and risk management. Midwives get good communication about MARAC from the specialist domestic violence nurse in the community health trust. In the MIUs, staff are alerted if the child or adult presents for treatment, which constitutes a valuable strand of risk assessment. Practitioners report good health engagement with MARAC and thorough information sharing between agencies. GPs attending the GP safeguarding forum also reported an understanding of MARAC arrangements, all of which contributes to comprehensive information exchange to help keep children and young people safe.

3.9 Overall, GPs are well engaged with safeguarding and child protection arrangements, although some still do not regard safeguarding as integral to their everyday role. The success of the GP safeguarding forum with a high number of practices represented is testament to the ongoing and forward thinking work of the designated doctor and named GP. We saw an example where a GP attended child protection conferences in her own time and highlighted the importance of a registrar attending with her as a continuous professional development (CPD) opportunity and to promote good safeguarding practice. We also saw an exemplary case where a GP had developed a report template to provide a detailed contribution to child protection conferences. This included the GPs observations of the interaction between parent and child which are routinely recorded in the child's records when attending the practice. This ensures the GP can best inform the child protection conference. Work is underway to audit GP contributions. Limited consideration has yet been given to widening the options to facilitate GP participation in child protection conferences, for example by holding the meetings at GP practices, using video or tele-conferencing etc.

3.10 GP practices visited have a clear and robust approach to any child identified as vulnerable or subject to child protection who fails to attend an appointment (DNA). They have good processes in place to ensure their vulnerable child databases are kept up-to-date. The clear flagging system in the practice enables the receptionist to see the child is subject to a CIN plan, child protection plan or is a looked after child and will alert the GP if the child does not attend. The GP then makes the decision on how to address this, either through ringing to offer another appointment, alerting another health professional or referring to children's social care. This provides a further mechanism to help keep children and young people visible and engaged with health services.

3.11 In GP practices visited, the health visitor meets with the database administration manager every month to go through the database and ensure it is up to date with correct flagging alerts and that pertinent information is shared.

3.12 Both GP practices visited prioritise child protection conferences and attend where possible. GPs routinely submitted written reports to conferences although each had different approaches to this: one using a template which she had developed and which has been disseminated to other GPs whereas the other wrote in the form of a letter. While the latter only recorded issues relating to the health of the child in the patient record, the former included observations of the interaction between parent and child when they attend the practice and her professional opinion of the parenting relationship with the child.

3.13 Liaison between the GP, health visitor and midwife in a case where the parent has not engaged with the child protection plan has not been strong outside of the formal child protection forums. Opportunities for the health visitor to join the practice's monthly meeting to discuss the ongoing needs and issues in the case and ensure close inter-professional co-operative working have not been fully explored (Recommendation 1.9).

**Case example:** MIU showed a persistent approach to follow up after a mother presented following a suicide attempt. After advising the mother to attend the ED department they liaised on an hourly basis with ED during the night to check if she had attended and when she had not, then contacted the GP, adult mental health crisis team and school nurse to ensure the children had arrived safely at school the next morning. The GP was then able to follow up and assist the Mother in attending ED whilst support was put in place for her children.

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## 4. Looked after children

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4.1 Foster carers told us they value the training on health topics which they receive and say that this has improved greatly over the past two years, particularly as some reported they are not routinely receiving copies of health plans. This training covers a range of topics, including everyday health, mental health and drugs and alcohol.

4.2 Clear learning from the previous inspection and the subsequent tendering process for Initial Health Assessments (IHA) has had a significantly positive impact on both the quality and timeliness of IHAs. Continual service improvement is in place and we saw evidence of an ongoing evaluative approach to IHA's, including designing additional parts to the British association for adoption and fostering (BAAF) paperwork to capture more historical information and ensure the GP is well briefed on the child or young person before the appointment. High priority was given to the voice of the child.

4.3 Foster carers told us their experience of the IHA now undertaken by the GP service is that they are good quality, thorough and the GPs undertaking them give everyone involved plenty of time and opportunity to talk separately about the child's health.

4.4 There are currently few asylum seekers in the area but the children in care GP has undertaken IHAs on some. She reports good support from a knowledgeable bank of interpreters who are also asked their view of the young person's cognitive and language skills. This ensures these elements of the assessment are not overlooked due to language issues, supporting direct engagement with the young person and leads to positive outcomes and the assurance that their needs are being identified.

4.5 A well-developed rolling programme of training, shadowing and staff coaching for health visitors and school nurses undertaking review health assessments (RHA) is in place. In some cases, challenge was seen in the system with individual feedback given to practitioners, coaching on the system provided, and the return of RHA's to practitioners if the quality of information needed to be improved. However in one case we looked at, where the RHA was recognised by practitioners to be of poor quality during the CLAS review, it remains unclear if the quality assurance process described was undertaken or if challenge was instigated. Further clarification of the system for all practitioners involved would be beneficial to ensuring consistency in the future and consistently improving the quality of RHAs (recommendation 1.10).

4.6 We did not see the use of strengths and difficulties questionnaires (SDQ's) within RHAs and a foster carer reported that despite the fact they completed it each year, there was no visible impact of this on the RHA and health plan. This family experienced a poor response to their worries about a young person's emotional and mental well-being, and concerns that they raised on SDQs were not responded to. This foster carer feels that they are not listened to and the views of professionals who do not know the child as well are prioritised whilst carer knowledge is not valued. The lack of value placed on their knowledge of the young person and her difficulties is, in their view, undermining her access to the support that she needs. The RHA process does not help in highlighting or addressing these issues. Opportunities to use SDQ's to allow young people to participate in tracking their own emotional growth are being lost (recommendation 1.11).

4.7 Good partnership arrangements are in place to raise health's profile with social worker colleagues via the social worker health forum that meets three times per year and the development of the CYPS pathways to allow rapid access for children in care (CIC). The consultation sessions run for foster carers and social workers are a welcome development in ensuring the needs of CIC are prioritised. Children in care requiring mental health intervention are prioritised and additional CYPS resource has been made available to meet their needs. CYPS provide good levels of support to foster carers and children do not have to be in stable placements to be eligible for CYPS intervention. We heard about cases illustrating the support given by CYPS to foster carers out of hours where placements were at high risk of breaking down.

**Case example:** *A 14 year old in care was well supported by the school nurse both in the initial child protection process and in providing on-going support for the young person regarding sexual health and contraceptive needs. The school nurse developed a clear plan of intervention around vulnerability, keeping safe regarding the internet, the young person's modelling work and relationships with peers. There was good liaison with CASH services with both CASH and the school nurse taking a holistic view of young person and jointly following up on any issues such as non-compliance with contraception when the young person failed to attend CASH appointments,. The young person is now engaging well with both services and the school nurse continues to support her.*

4.8 Health care summaries provided to care leavers have been developed but capacity pressures within the CIC health team has limited this area of developmental work. Young people were consulted on options a number of years ago however no tangible changes have been made following their specific feedback, for example service users requested health care summaries at age 16 and this has not yet been actioned - the idea of a health passport for care leavers subsequently identified as a resource to be developed has not been embedded in the service. The brief health summary document provided gives basic information but is not comprehensive or attractive to young people. No consideration has been given to adaptations to these documents to make it more accessible to young people with additional language or learning needs. In one case we saw, the summary had not been provided on the basis that the young person would not understand the information contained within it. This remains an area for development (recommendation 1.12).

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## Management

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

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### 5.1 Leadership and management

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5.1.1 The provision of a paediatric liaison health visitor (PLHV) role with regular attendance visits across the Gloucester Hospitals NHS Foundation Trust (GHFT) sites and by request of the MIUs is a strength. The role is seen as integral to the safeguarding arrangements across these acute services and the post holder is well known and well regarded by frontline staff in the EDs. As the paediatric liaison health visitor post holder is moving on, the role is currently under review. This CLAS review has highlighted the impact of a previous capacity reduction in this service whereby the reduction in hours had a negative impact on the PLHV's ability to review all under 18 presentations.

5.1.2 The PLHV no longer has the capacity to review every under 18 who attends ED or the MIUs. However, Gloucester Hospital NHS Foundation Trust frontline practitioners in ED are operating under the misapprehension this review is taking place. As this mechanism for safeguarding concerns to be identified is not fully operational, some children and young people are potentially being exposed to risk on discharge with no follow up in place.

5.1.3 The designated doctor and named doctor for safeguarding children provide strong leadership to the cohort of Gloucestershire GPs. The designated doctor is working well with other agencies, enabling GPs to benefit from expert input from police, health visitors and other disciplines with a focus on safeguarding at the GP forum. She provides decisive leadership, advice and guidance and is effective in helping GPs understand their roles and responsibilities and is driving the development of consistent good practice across primary care.

5.1.4 The use of a single patient information system across the MIUs run by Gloucestershire Care Services NHS trust and the EDs in Cheltenham and Gloucester run by GHFT facilitates effective information sharing about children and young people accessing these services. It also enables effective tracking of the frequency and locations of presentations for treatment within the catchment area. We are aware that changes in systems are planned however the ability to capture and manage the essential safeguarding information of the single IT system should be prioritised (recommendation 1.6 and 2.5).

5.1.5 We have seen health services which are open to learning and this is a strength. A number of examples of practice improvements which had been introduced as a result of past serious case reviews (SCR) are now established. Partners have used both the Significant Incident Learning process (SILP) and Social Care Institute for Excellence (SCIE) review model to good effect, with learning roadshow events taking place to cascade learning and support staff in working with families who are particularly difficult to engage.

5.1.6 Commissioners and CYPS are working together to identify where pressures on the mental health service are impacting on capacity and increasing the likelihood of young people having to wait for intervention. Additional investment by commissioners is aimed to ease some of these pressures particularly resulting from the high incidence of DSH among teenagers.

5.1.7 GPs report very limited access to school nurses due to lack of capacity in that service. One GP we spoke with was trying to secure school nurse attendance at the monthly practice meetings at least twice a year. Action is being taken to address staffing issues across the school nurse teams, including recruitment drives, prioritisation of work, steps to address workload management including centralised /targeted training, restorative supervision and a 'triage' tool to determine attendance at strategy meetings. School nurses find these useful tools but the underlying issue relating to staffing numbers continues to be a significant issue affecting capacity to work effectively.

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## 5.2 Governance

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5.2.1 Operational governance of safeguarding practice in acute services (ED and MIU) is underdeveloped. The paediatric liaison health visitor will report, as an incident, all individual cases where she has to take some action or address sub-optimal practice and will also feedback to the safeguarding lead ED consultant on individual cases to help improve practice on an informal basis. However, several cases we reviewed demonstrated a lack of thorough probing of information given or incomplete risk assessment documentation and it was unclear how these issues are addressed with individual practitioners, or by ensuring processes are strengthened to ensure a culture of continuous improvement. We have identified a number of cases where safeguarding issues have not been identified and acted upon by clinical staff. Therefore, both GHNHSFT and GCSNHST cannot be assured that all young people are safe when discharged from unscheduled care services (recommendations 1.7 and 2.9).

5.2.2 GHNHSFT has a practice development nurse to oversee all training for nurses across unscheduled care. However, the arrangements for safeguarding training do not appear to be compliant with inter-collegiate guidance regarding staff identified for Level 3 training, and there has been no consideration of meeting /demonstrating competency standards. Senior staff that we met were unaware of compliance with training across medical staff and reception staff (who are not directly employed by the Trust). GHNHSFT cannot assure itself of compliance with inter collegiate guidance standards particularly relating to level 3 training.

5.2.3 The 2Gether Trust's IT system is set up to provide a framework that ensures care planning is driven by current best practice and national policy drivers. However, the current configuration of the IT system was experienced as challenging by practitioners and at times counter-productive to assessment, care planning and recording by practitioners. During the review, it was difficult to identify historical information and track the pathway of a person through time, which could undermine individual care planning and result in less than optimal outcomes.

5.2.4 With reference to record keeping, there is more to do to ensure records are fully integrated as a new born baby moves from midwifery services into health visitor services. The current mismatch between a paper based service in midwifery and a paperless service in health visiting presents challenges in information sharing and ensuring that risk intelligence is appropriately captured and transferred. Some records seen had a significantly incomplete history of the mother and of practitioner intervention. In addition to the risk that this presents to promoting good practice and outcomes for mothers and babies, it means that managers would face significant challenges in auditing and quality assuring practice. Dispersed paper records in midwifery mean that other members of team may not be aware of issues or have timely access to notes, which undermines information sharing and continuity of care. It is of concern that issues relating to checks on safety e.g. Domestic violence are noted in the hand held notes retained by the mother rather than noted in the clinic records available to staff leading to potential gaps in practitioner awareness of mother and unborns' vulnerabilities and needs.

5.2.5 Copies of referrals made to children's social care from CYPS staff are not copied to the mental health named nurse for safeguarding and therefore an opportunity for effective quality assurance and progress monitoring is lost (recommendation 3.6).

5.2.6 There is variable recording practice across services. Some systems we observed were not fit for purpose and there are issues around data quality and corruption in the ISH services particularly, which has a significant impact on accurate information. This leads to an inherent risk that children and young people's needs and vulnerabilities are not fully addressed.

5.2.7 Within CIC, there are limited formal oversight and governance arrangements in place at present, although the team are extremely proactive in undertaking audits to continually develop and evaluate their service, of their own volition. The team are providing information to GCSNHST children's services operational board meetings and provide an annual health report for children in care. The implementation of annual IHA/RHA audits, the joint audit with social care and the impending outcomes audit around progress with health recommendations in April 2014 highlights that the CIC team are outcome focused and this is having a positive impact on CIC health needs being met.

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## 5.3 Training and supervision

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5.3.1 The well-established GP forum is attended by GPs from across the county and participants told us that they find it informative and that it is helping to drive improved safeguarding practice in primary care. The forum provides a supportive environment for practice safeguarding leads to develop their knowledge and understanding of safeguarding issues, current research and good practice through expert speakers and the use of case studies. GPs have online access to CCG safeguarding resources and e-learning encompassing level 1 and 2 training. GPs however are not accessing the GSCB safeguarding level 3 training optimally.

5.3.2 Supervision is robust in the CIC team with the designated nurse for children in care meeting with the designated doctor and designated nurse for safeguarding on a monthly basis, along with access to group supervision by named nurses. The specialist nurse for children in care also meets regularly with the designated nurse for children in care. GP's at Hadwen Medical Group responsible for IHAs receive supervision from the designated doctor. Due to the number of provider services involved with CIC healthcare, a professional group has been set up to meet twice yearly to include 2gether trust, GP, designated doctor and CIC nurses. This is good practice to facilitate discussion around shared issues and service development plans.

5.3.3 One-to-one safeguarding supervision for health visitors and school nurses is well secured and established. Practitioners have supervision every three months. Nursery nurses are supervised as a group in four sessions per year. Health visitors told us how much they value the support they get from having 1:1 supervision in ensuring their safeguarding practice is continuously moving forward.

5.3.4 Gloucestershire Care Services NHS trust have a clear children's safeguarding supervision policy in place, based on the statutory guidance set out in Working Together 2013 and which is available to staff on the trust's intranet. However, some of the MIU's do not have safeguarding supervision arrangements. and were not aware of the trust's policy until this review. Compliance of services with the trust's policy is not monitored effectively. There is not sufficient impetus being given to ensure that MIU staff regularly receive safeguarding supervision and services are not compliant with statutory guidance or the care service trust's own safeguarding supervision policy. The approach to safeguarding supervision in the Care Services trust lacks rigor and as a result some practitioners are not accessing regular, planned supervision (recommendation 1.3).

5.3.5 Staff at the ISH service have completed Levels 1 and 2 combined safeguarding training and the service manager has completed level 4. There is a lack of decisiveness within the service as to whether staff should have level 3 training. However, managers have recently undertaken a review of training and this has identified gaps in staff knowledge. There is a planned slot in the senior operational management meeting to review this. All staff have access on a quarterly basis to safeguarding supervision with the named nurse for the care services trust and access to multi-agency supervision which they should access four times per year. Staff are reported to be released to attend these sessions, although it is unclear if they are able to consistently attend at present.

5.3.6 The 2gether Trust has a policy that safeguarding leads are identified on all in-patient wards, which are trained to intercollegiate level 3 standards, and two staff are trained on the ward where most young people are admitted. Training in adult mental health services regarding "Think Family" is at level 2 and although the adult mental health team is moving forward at prioritising children's safeguarding over the adult's mental health, some cases we have seen highlight the service is not yet delivering a sufficiently robust "Think Family" model (recommendation 3.2).

5.3.7 Supervision arrangements within CYPS are underdeveloped. The CYPS safeguarding named nurse provides group safeguarding supervision every 3 months to practitioners. Safeguarding is an agenda item on team meetings on alternate weeks and practitioners make good use of opportunities for ad hoc advice and guidance in the absence of more formalised arrangements (recommendation 3.1).

5.3.8 The recently introduced safeguarding forum in GHFT which uses case studies to facilitate a reflective practice/group supervision approach has proved beneficial to attendees and is moving from two monthly to monthly. However, GHFT have acknowledged that safeguarding supervision arrangements in line with Working Together 2013 are not embedded in midwifery and ED services. In general, supervision arrangements are variable across services and there is currently some over reliance on informal ad hoc supervision requested by the practitioner (recommendation 2.7).

5.3.9 Staff at the Integrated Sexual Health service (ISH) are undergoing Child Sexual Exploitation (CSE) training although not all have completed this yet. Discussions have been underway since October 2013 with a representative from the Police and there is a plan for him to attend to deliver more training as part of staff's protected monthly training session. Staff who have had training are using the CSE assessment toolkit and this was appropriately and well used in two cases seen.

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# Recommendations

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- 1 Gloucestershire CCG with Gloucestershire County Council and Gloucestershire Care Services NHS Trust should ensure;**
  - 1.1 that the role of the paediatric liaison health visitor is reviewed to include oversight of all under 18 presentations in the Minor Injury Units and clarified for staff to ensure they are fully aware of the responsibilities, process and outcomes when making referrals
  - 1.2 that written records of discussion are formally recorded both by staff and by the Paediatric Liaison Health Visitor
  - 1.3 that formal safeguarding supervision arrangements are put in place and monitored for Minor Injury Unit staff based on the statutory guidance set out in Working Together 2013 and in line with current Trust policy
  - 1.4 that automatic referral pathways for young people substance misuse services are embedded in Minor Injury Unit practice
  - 1.5 that practitioner referrals to children's social care from Minor Injury Units clearly articulate the risks to the child or young person in order to facilitate effective decision making
  - 1.6 that consideration is given to keeping a common IT system across Emergency Department and Minor Injury Unit departments to ensure the current arrangement for robust information sharing is maintained
  - 1.7 that practitioners in the Minor Injury Units are encouraged and supported with effective monitoring to ensure safeguarding activity and risk assessment is comprehensive and effective.
  - 1.8 that further awareness raising on the role of the Turn Around for Children service is cascaded across all staff who are in contact with families and children under 5.
  - 1.9 that mechanisms are put in place to support health visitors and school nurses routinely attend GP practice meetings
  - 1.10 that there is effective quality assurance of review health assessments carried out to ensure they are of a consistently high standard
  - 1.11 that the use of SDQ information gained from young people and carers is recorded to a satisfactory standard and that health plans take account of SDQ findings so that appropriate plans can be put in place to respond to the needs identified

1.12 that over 16's and care leavers are properly equipped with comprehensive, age appropriate health history information and contact details should they need to re-engage with the Children in Care team, in line with the specific requests made by care leavers as part of service user consultation in 2011.

**2 Gloucestershire CCG with Gloucestershire County Council and Gloucester Hospitals NHS Foundation Trust and should ensure;**

2.1 that the use of the formal supervision arrangements such as the midwifery safeguarding forum is accessed by staff on a regular basis and attendance robustly monitored

2.2 that a regular multi-agency maternity liaison meeting is established to update and exchange information on vulnerable pregnant women

2.3 that service delivery models are considered to improve and allow more equitable access to the teenage pregnancy midwifery service

2.4 that safeguarding practice within the Emergency Department is of a high standard, with routine oversight of the completion of safeguarding risk assessment in notes

2.5 that consideration is given to maintaining a common IT system across Emergency Department and Minor Injury Units as it has a significant contribution in information sharing and keeping children and young people safe

2.6 that safeguarding training compliance is monitored to ensure all staff undertake child safeguarding training at a level commensurate with their roles and responsibilities in line with Working Together 2013.

2.7 that all practitioners, particularly those in midwifery and emergency departments, whose day to day work requires a high level of understanding and competence in safeguarding for children and young people and child protection receive regular, formal ,safeguarding supervision in line with statutory guidance.

2.8 that staff in the Emergency Department are made aware of automatic referral pathways for young people substance misuse services and that this is embedded in Emergency Department practice

2.9 that practitioner reports and records of safeguarding risk assessment documentation in the Emergency Departments are completed comprehensively

2.10 that the role of the paediatric liaison health visitor is reviewed to include oversight of all under 18 presentations in the Emergency Departments and clarified for staff to ensure that they are fully aware of the responsibilities, process and outcomes when making referrals

### **3 Gloucestershire CCG with Gloucestershire County Council and Together NHS Foundation Trust should ensure that**

- 3.1 all CYPS practitioners receive regular, formal, safeguarding supervision in line with statutory guidance.
- 3.2 that all adult mental health workers undertake formal training in the “Think Family” approach and that this model is embedded in service delivery
- 3.3 that adult mental health workers are engaged effectively in child in need and child protection processes, including attendance at CAF meetings
- 3.4 that CYPS practitioners are supported to liaise effectively and work in partnership with out of area Tier 4 providers on a case by case basis
- 3.5 that all young people who require specialist support have timely access to the specialist CYPS 3.5 service
- 3.6 that safeguarding referrals made to children’s social care are routinely copied to the named nurse for safeguarding to assure effective quality assurance and consistent reporting arrangements.
- 3.7 that Practitioners in adult mental health services routinely document the impact of parental mental health on young people and include the child or young persons’ needs in care plans

### **4 NHS England Area team in partnership with the CCG should ensure;**

- 4.1 tier 4 specialist CAMHS provision access is reviewed with regard to capacity due to the local trends around deliberate self-harming and high numbers of young people being admitted to adult wards.

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#### Next steps

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

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