

Review of health services for Children Looked After and Safeguarding in Nottingham City

Children Looked After and Safeguarding

The role of health services in Nottingham city

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Name(s) of CQC inspector:	Lee McWilliam Janet Lewitt Lynette Ranson
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CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care	Ms Janet Williamson

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Nottingham City. 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 Nottingham city , cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

Context of the review

The majority of Nottingham City residents (95%) are registered with GP practices that are part of the NHS Nottingham City Clinical Commissioning Group (311,669 residents).

Children and young people make up 26% of Nottingham City's population with 46% of school age children being from a black or minority ethnic group. On the whole, the health and well-being of children in Nottingham City is generally worse than the England average. Both the infant mortality rate and the child mortality rate in Nottingham City are similar to the England average.

The rate of LAC under age 18 per 10,000 children as at March 2013, was significantly worse when compared against the England average. Chi Mat reported that in 2013, the percentage of children in care within Nottingham City with up to date immunisations was significantly better to the English average.

The indicator for the rate of ED attendances for children under four years of age in 2011/12 was significantly worse than the England average. With regards to mental health, the rate of hospital admissions for mental health conditions and the rate of hospital admissions as a result of self-harm in 2012/13 was not significantly different to the England average.

In 2011, the conception rate for under 18 year olds per 1000 females in Nottingham City was significantly worse when compared to the England average. The percentage of teenage mothers in the area in 2012/13 was also significantly worse to the England average. Breastfeeding indicators were mixed; the breastfeeding initiation indicator was significantly worse than average and the breast feeding prevalence at 6-8 weeks after birth indicator was similar to the England average. Chi Mat also indicates that in Nottingham City there are issues with childhood obesity, children with missing or decayed teeth and low birth weight.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Nottingham City. The average score per child in 2013 was 15. This score is considered to be a borderline cause for concern. The average score over the last two years has generally remained consistent although in 2013 there was a small increase in the average score, which maybe an indication that the emotional wellbeing of children is starting to deteriorate.

In 2013, the Department for Education reported that Nottingham City had 370 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). This is an increase from 2012. DfE reported that 80% of children had their immunisations up to date. 85% received their annual health assessment and 92% of LAC had their teeth checked by a dentist. As at 31 March 2013, there were 90 looked after children who were aged five or younger, 83% of these children had up to date development assessments.

There are 3 main Health providers in Nottingham City. Nottingham CityCare Partnership provides community services across Nottingham City including Health Visiting service, School Nursing service, Family Nurse Partnership service, a baby feeding service for under 25 year olds and a Children's Continuing Care service. The CityCare Partnership also have a walk in centre.

Nottinghamshire Healthcare Trust provides integrated healthcare services, including mental health, learning disability and community health services. The trust has a Paediatric Liaison Health Visiting Team which covers both Nottingham City and Nottinghamshire County. They also provide the Children in Care and Adoption Health Team. This team provides a health service specifically designed for children in care and children on an adoption pathway across Nottingham City and Nottinghamshire County.

Nottinghamshire Healthcare Trust also provide Tier 3 Specialist Community Child and Adolescent Mental Health services (CAMHS); CAMHS Day Service (Intensive Treatment Team); CAMHS Head 2 Head- substance misuse mental health assessment team; CAMHS Looked After Children service for City children and the CAMHS Adolescent Unit. This adolescent unit is a 12 bedded inpatient facility for 12 to 18 year olds experiencing mental health problems.

Nottingham University Hospitals NHS trust (NUH) is based in the heart of Nottingham and has three separate sites around the city. The trust has an ED department and provides maternity services.

Commissioning and planning of most health services for children are carried out by NHS Nottingham City CCG and Nottingham City Council (Public Health).

Commissioning arrangements for looked-after children's health are the responsibility of NHS Nottingham City CCG and the looked-after children's health team, designated roles and operational looked-after children's nurses, are provided by Nottingham University Hospitals NHS Trust (Doctors) and Nottinghamshire Healthcare Trust (Nursing).

Acute hospital services are provided by Nottingham University Hospitals NHS Trust.

School nurse services are commissioned by Nottingham City Council (Public Health) and provided by Nottingham CityCare Partnership.

Contraception and sexual health services (CASH) are commissioned by Nottingham City Council (Public Health) and provided by Nottingham University Hospitals NHS Trust.

Child substance misuse services are commissioned by Nottingham City Council Crime and Drugs Partnership (CDP) and provided by Nottinghamshire Healthcare Trust.

Adult substance misuse services are commissioned by Nottingham City Council Crime and Drugs Partnership (CDP) and provided by Nottinghamshire Healthcare Trust.

Child and Adolescent Mental Health Services (CAMHS) are provided by Nottinghamshire Healthcare Trust.

Adult mental health services are provided by Nottinghamshire Healthcare NHS Trust.

The Nottingham City integrated inspection of Safeguarding and Looked After Children's Services (SLAC) took place in November and December 2010 (published in January 2011). Both the 'overall effectiveness of the safeguarding services' outcome and the 'overall effectiveness of services for looked after children and young people' outcome were assessed as good.

There were five recommendations following the report

- Nottinghamshire Healthcare Trust and Nottingham City Council must ensure that referral status is effectively feedback to the referrer in a timely manner and that the health action plans for looked after children are updated accordingly in order that ongoing monitoring of emotional wellbeing is effective.
- Nottingham City Council and the looked after children and adoption health team at CitiHealth must ensure that the use of the Strength and Difficulties Questionnaires (SDQ) is fully embedded into the annual health assessments in order that full physical, emotional and mental health assessments take place.

- Nottingham University Hospitals NHS Trust and partner agencies must ensure that the gap in provision is addressed for those young people who present at the emergency department and who are homeless, in order to optimise their treatment and safety.
- Health partners must ensure that there continues to be effective and efficient access to safeguarding health advice for general practitioners and other primary care workers in order that the absence of a named general practitioner does not adversely affect outcomes for children and young people.
- Nottingham City Council with NHS Nottingham City must ensure that general practitioners are regularly updated on referral processes to children's social care and are made aware of early intervention services, including CAF, and can receive general advice on all safeguarding matters.

These recommendations are covered in the report.

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

A young person we met at the CASH clinic told us she attends regularly and sees the same nurse, “*She’s great. I can speak to her freely, she always gives advice too.*” We heard that the CASH nurse helped this young person when she had women’s health issues that weren’t being picked up by GP.

Another young person told us “*The nurse at City cash clinic used to be my school nurse, she was really great and it was really nice to see her at the clinic as it made it easier to talk about stuff.*”

A young person who has left care told us how her regular health review by a consistent person had helped to meet her health needs and to “*grow up successfully*”. She said “*I really enjoyed them actually, the nurse was great*”.

A foster carer told us: the GP is “*brilliant*” “*it’s no problem to see him on same day*” and the LAC service is “*spot on*”; “*we’re really impressed with service*”.

Other foster carers told us,
“*The Paeds department is excellent, they have given a brilliant service to all the children with health problems*”.

“*sometimes you seem to have to put a lot of pressure on and to be very persistent to sort things out which should be simple*”.

“*we are made to feel we are over-concerned about things and brushed aside, we are often not taken notice of, but often we are proved right. We are the ones who know the child and our knowledge should be better respected alongside other professionals.*”

We heard from foster carers that there is a problem with dentists in Nottingham taking on new patients, meaning that foster carers have to go to wherever the child was registered before or “*shop around to find one, and that means you might be taking all the children to different places every six months. If a dentist was clarified at point of fostering or there was an agreement that dentists would take on LAC or better still, that the dental checks could be done at the same time as the health reviews, that would be wonderful for children, foster carers and parents*”.

One team we visited said :The CCG is ‘*nothing short of remarkable*’

The child's journey

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

1 Early help

1.1 Many vulnerable children, young people and families in Nottingham have access to an established and evolving range of health and social care led early help services which are effective in delivering positive outcomes; examples include the Family Nurse Partnership (FNP) which is well valued and regarded throughout all the services we visited. However in some service areas, the early help offer is currently limited by capacity pressures. We are aware of a number of changes planned across services for example the school nursing service which will address the need for prevention and health promotion work particularly around the areas of healthy lifestyle, emotional wellbeing and sexual health in response to the issues currently being experienced by the school health team due to vacancy levels.

1.2 The wide range of specialist midwifery posts including Substance Misuse, Teenage pregnancy, Maternal Mental Health, and Domestic Violence contribute to ensuring women with additional needs and vulnerabilities are supported throughout their pregnancy by facilitating access to services at an early stage.

1.3 Joint working between midwives and health visitors is good. The impact of the health visitor Call to Action programme is starting to permeate and with this there are increased opportunities to transform the service by a tripling of the health visitor workforce and a 'growing your own' approach to recruitment and retention of their own practitioners. Changes in models of practice have occurred due to having 42 students currently in training. Increasing numbers of health visitors in practice can now visit targeted clients during the ante natal period. These visits allow early intervention with a family to work towards positive outcomes for the family and child. However, targeted antenatal visits to all who require them are not yet routine practice. This is a gap in providing consistent support and continuity of care for vulnerable families. (**Recommendation 1.1**)

1.4 Strong arrangements are in place to provide targeted support by the health visitor team for children and families that are extremely vulnerable. The vulnerable person team – which includes a skill mix team of health visitor practitioner and band 5 & 6 nurses work with the homeless, asylum seekers, traveller community and young people known to the Youth Offending Team. In addition, a maternal mental health practitioner works with the team and the FNP staff to ensure families with additional needs are well supported.

1.5 The health visiting service is proactive and innovative in its approach when responding to the needs of the local population and emerging trends. New initiatives include the implementation of a pilot minor ailments clinic, run by a health visitor trained in minor ailments and based in a range of community settings. The intention of this is to deflect and reduce attendance at ED for the population of under 4s.

1.6 Families where parents experience mental health issues would be further protected and practitioners may be able to intervene earlier if practitioners were aware of signs of relapse. Health visiting are not routinely advised by mental health colleagues of the ‘signs of relapse’ when dealing with families with mental health issues and an emphasis is placed on the health visitor practitioners to instigate contact with the Adult mental health (AMH) team for advice. (**Recommendation 2.1**)

1.7 We saw variability in the quality of plans in health visiting notes. Some contained insufficient detail and the use of clear outcomes and timescales was not utilised effectively. (**Recommendation 1.2**)

1.8 In a number of cases, we saw good evidence of the adaptability of the FNP worker when trying to engage with the client. There was a perseverance by the FNP worker in attempting to engage some particularly hard to reach families, and in all cases, this persistence paid off and the families were continuing to access FNP intervention.

1.9 The perinatal mental health protocol is well used and highly regarded. We saw good awareness of this particularly within GP services. However there is scope to clarify pathways where a mother to be declines involvement with the perinatal mental health service, and where the AMH worker continues to be the lead professional.

1.10 The “Red card” liaison meetings held in many GP practices support safeguarding around families about whom there are concerns and is a very positive offer. In some practices we saw exemplary practice where this is working very well with discussions and actions clearly minuted and outcomes followed up across teams. This information exchange helps to ensure the needs of the child and family are met in a co-ordinated manner and contributes to keeping children and young people safe.

1.11 Within some GP clusters, the current arrangements and terms of reference for Red card meetings require review, particularly seeking solutions to support practices which are currently less able to achieve this regular liaison, including a consistency check to ensure the red card meetings are being utilised most effectively in all practices. In one case we saw, more robust and frequent liaison arrangements might have ensured that the family’s inability to meet the children’s health needs was addressed in more timely fashion. (**Recommendation 4.1**)

1.12 Capacity issues are currently preventing school nurses from routinely attending “red card meetings” and prioritisation of this would ensure their valuable contribution to the health needs of children and young people is heard. (**Recommendation 1.3**)

1.13 Some health professionals reported difficulty in securing good and consistent liaison with adult mental health workers and in one case example seen, where concerns were raised with adult mental health about a parent, there was limited action or follow up. (**Recommendation 2.2**)

1.14 A strong perception remains that access to Tier 3 CAMHS therapeutic services is subject to high thresholds and long wait times although in the cases we saw, none had experienced significant waiting times and in some cases access was prompt.

1.15 We did see evidence of unacceptable practice of children moved between informal, T2 and T3 CAMHS services which wastes resources and delays access to service. We are aware of the significant changes to Tier 1-3 services due to be implemented over a two year period starting in September 2014. Despite this being a long term and ambitious plan, it is anticipated many of the current issues associated with processes and transition between tiers will be alleviated through its implementation.

1.16 The planned implementation of an emotional health and wellbeing pathway is enthusiastically anticipated by health professionals across the patch and should provide a high level of support at an early stage for families and young people, leading to increasingly positive outcomes. We have been assured by commissioners that the core business will be prioritised in the interim period to ensure children and young person's needs continue to be met whilst the new model is being implemented. Further work needs to include clarification that the CAMH Service recognises and is able to respond with escalation or referral, where a young people's health needs or circumstances indicate safeguarding or protection is needed.

1.17 The young person sexual health offer is strong, with a variety of times and locations for young people to access drop ins or booked appointments to engage with a fully integrated service including contraception, sexual health, health promotion and termination of pregnancy. Feedback from service users is being used to further develop services including the consideration of an appointment system at the Victoria Health centre, where waiting times during drop in sessions can be up to three hours. This affects young people's willingness to wait and access the service.

1.18 The introduction of a CASH clinic at one of the city academy schools is also providing additional access for young people. Close liaison and training with school nurses ensures young people have additional follow up where appropriate.

1.19 CASH staff are aware of the specific vulnerabilities of young people who are under 13 and effective mechanisms are in place for referral of these young people to the specialist complex needs clinic, run by a paediatrician weekly. This ensures their circumstances are reviewed by a senior practitioner, both from a medical and safeguarding perspective and risks are comprehensively assessed.

1.20 Within CASH we saw a high standard of record keeping and a persistent approach to follow up with other agencies. The use of joined up IT systems between clinics acts as a further safety net to track young people's attendance across the city, and helps identify patterns in attendance, for example the identification of a high number of young people attending from one residential home. This allowed staff to be proactive in offering training to staff in this home and making additional visits to discuss sexual health issues.

"B" is a young person who has stayed in touch with the CASH service for over 4 years, in which time the CASH nurse has been a consistent health professional that she could seek advice from. The benefit of this consistency in staff and trusted relationship meant that "B" felt that she could return to them with concerns related to her friend, who other health professionals were struggling to engage with. The CASH nurse was able to establish contact and signpost to appropriate services to support this young person's needs.

1.21 We are aware that the Walk In Centres across the city are under review at present. Whilst there is a range of locations and providers, there is currently a lack of 24 hour walk in centre provision with a steady pattern of attendance. The ED department at Queens Medical Centre Campus however has seen its numbers increase from 350 to 500 presentations per day, approximately 25% of whom are children. (**Recommendation 1.4**)

1.22 The Walk in centre visited did not have robust arrangements in place for children, particularly with regard to paediatric trained staff and facilities. It is recognised by staff that the site lacks child friendly facilities while children wait to be seen. The high design of the counter is also such that staff can't easily observe the waiting area or family interactions as they are seated below the counter's eye sight level. The ticket system on entry does not prioritise children and young people and with the high numbers of children attending, this needs urgent review. In one case seen, a baby with an unexplained head injury waited with a ticket for 45 minutes to be triaged at reception by a Nurse Practitioner before then being sent to ED as per head injury protocol and admitted overnight due to safeguarding concerns. In another case, insufficient details at triage were taken or recorded about family members. This approach is detrimental and hampers staff's ability to ensure children and young people are safe. (**Recommendation 1.5**)

1.23 Some excellent examples of safeguarding risk assessment were seen in ED at Queens Medical Centre Campus, with effective identification of vulnerabilities for the child and/or the family and appropriate referral for community follow up. We saw robust probing of full information to ensure that all safeguarding issues are identified and acted upon appropriately.

1.24 There is an effective Paediatric Liaison Health Visitor (PLHV) team that are clearly visible within the ED department, acting as a channel into community services to ensure follow up of safeguarding concerns and children's needs. Due to the large numbers of children passing through the department, there are concerns with capacity for the PLHV role, and therefore at present they do not have the ability to review all under 18 presentations. Whilst the impact of having well trained and experienced Paediatric staffing within ED meant we were assured that safeguarding was highly prioritised, there is an over-reliance on the skills and experience of the staff rather than the presence of additional safety nets such as the PLHV overview to ensure all children are discharged safely. (**Recommendation 2.3**)

1.25 Currently, practitioners in ED make good use of a free text box to record any safeguarding queries on a child or young person's electronic notes, however this carries an inherent risk and an emphasis on the practitioner to ask these questions and record appropriately. The ability to have mandatory safeguarding categories on IT systems within the ED department would act as visual prompts for staff and further ensure any safeguarding concerns surrounding the child are consistently captured. (**Recommendation 3.1**)

1.26 The dedicated paediatric ED has good facilities for younger children however the environment is not conducive for adolescents to wait in, particularly if they are awaiting assessment from the Department of Psychiatric Medicine, which, due to limited capacity means a young person may be waiting for a significant amount of time. Both this capacity issue, and the provision of more appropriate facilities should be addressed to prevent additional stress being placed on highly vulnerable young people in the emergency setting, whilst they are awaiting appropriate treatment. (**Recommendation 3.2**)

1.27 Children and young people aged up to 16 attending Queens Medical Centre Campus ED with mental health issues have access to CAMHS assessment within one working day depending on time of referral. This is not routinely available at weekends. We have seen and heard about a number of cases where young people would have benefitted from access to an established on call CAMHS crisis team to provide the most appropriate support and treatment to them and prevent escalation of their presentation. (**Recommendation 2.4**)

1.28 Head 2 Head, the young person substance misuse service, are highly flexible in their approaches to engage young people with substance misuse and mental health issues and we saw very positive outcomes. Their assessments are comprehensive and information is shared effectively to ensure the young person's rapid access to appropriate services. The remit of Head 2 Head to include work with Youth offending team and CAMHS clients is mutually beneficial, especially for young people who are resistant to being involved with the core CAMHS service.

1.29 A robust pathway for referrals from ED into Head 2 Head is not however in place; and the establishment of this, alongside awareness work with ED staff would be beneficial to ensure this type of intervention is considered on a routine basis when young people present with substance misuse and mental health issues. (**Recommendation 3.3**)

1.30 Within adult substance misuse services (known locally as Recovery), Think Family is embedded. The Explore family support service which works to support families and children of substance misusers to address the negative impact and improve family functioning is a positive development to ensure not only safeguarding issues are addressed but to provide high levels of support to achieve best outcomes.

1.31 The substance misuse midwifery team is located with the drugs service, which makes communication more effective and enables parents to be to have drug testing carried out at the same time as midwifery appointments. The service, involving the substance misuse midwife and specialist drug worker, stay involved with the mother until there is a natural break in treatment, contributing to continuity of care and relationship building both ante natally and post natally. Both workers are involved with the monthly multi-agency pregnancy liaison group (MAPLAG) meetings which facilitates strong information sharing and risk assessment for unborns.

1.32 Within cases we sampled in Recovery, the standard format paperwork which is used locally as a CAF was not fully completed. In some cases seen, where the risks involved more than one child in the family, information was split over different forms. This is not conducive to practitioners having the full picture and being able to risk assess and support families and children holistically.

1.33 Across health services, we saw assessments of children and families that are comprehensive, however the care planning is not SMART and outcome focused, with a tendency to be task rather than goal orientated. This results in difficulties for both practitioners and families to know when they have achieved desirable outcomes and that children and families are making sufficiently rapid progress to avoid drift in cases.

Adult A attended CASH clinic following fleeing from another part of the country to seek refuge with local relatives, following domestic violence. Subsequent information obtained by CASH nurse highlighted ongoing mental health and self-harming needs and that children had been left with violent partner. Rapid and comprehensive enquiries made by the CASH nurse with out of area teams led to children being taken to place of safety and "A" being supported both for mental health needs and via Domestic Abuse Referral team and Women's Aid support.

2 Children in need

2.1 Good inter agency working between midwifery and children's social care ensures the most vulnerable cases are reviewed regularly. The named midwife is extremely supportive to midwives and will work with them to improve quality of referrals if they are identified as not meeting thresholds for Child in need plans. The Neighbourhood Fieldwork Management Meeting (NFMM) meets monthly and is a forum for key health professionals for safeguarding, including the named midwife to meet with Nottingham City social care and escalate cases of concern.

2.2 The Multi-Agency professional liaison group (MAPLAG) that is led by midwifery contributes to enhanced practitioner understanding of the complex needs of some of the most vulnerable families and children, allowing appropriate referral to the service that is most suitable for their needs . The wide ranging representation on this group including NSPCC, social care, Domestic Abuse team, Probation, substance misuse, Safeguarding teams from provider organisations and "parents under pressure" lead meet monthly to discuss families with ongoing needs. Decisions on the most appropriate line of action and input (for example CAF, referral to social care, NSPCC Parent under pressure programme) are made jointly as a group, which improves cohesive contribution between agencies, to best support children and young people's needs.

2.3 There is more to do to ensure all health agencies involved are aware that MAPLAG information is available on SystmOne. Currently there is not a robust system that ensures all minutes of the MAPLAG meeting are uploaded onto the electronic systems and review of some files indicated that that some information from MAPLAG had been transferred onto the safeguarding section of SystmOne whilst others had not. (**Recommendation 3.4**)

2.4 An easy to recognise icon system on SystmOne ensures that young people's safeguarding status is picked up immediately by midwifery staff. However there are no mandatory fields for safeguarding issues, with an over-reliance on free text entry. This is not a robust system to ensure that all safeguarding concerns are documented. (**Recommendation 3.5**)

2.5 The arrangements for Domestic Abuse flagging within Adult ED are safe and efficient. The Domestic Abuse liaison nurse within ED acts as an effective link between acute staff, MARAC and the DART team (Domestic Abuse referral team) and will put alerts on the system and remove them when appropriate for children in families where there is Domestic abuse. This systematic recording of up to date information assures any concerns are identified and that staff are aware of safeguarding vulnerabilities for the child/young person.

2.6 The Emotional Health Nurse within ED is a newly created post that has, within 2 weeks of implementation, already had a rapid impact on preventing recurring admission for one young person with mental health needs to hospital. This is a very positive development, ensuring children and young people with emotional needs are accessing appropriate ongoing community support to prevent hospital admission.

Child S attended ED with self-harm and previous history of self-harm. Following medical treatment, she was seen by the Emotional Health (EH) nurse and signposted to support systems in the community. Following discharge, the EH nurse liaised with her GP and maintained contact with S and her mother. When her mood deteriorated, the EH nurse was able to see her again quickly and averted admission to ED. The EH nurse showed rapid recognition of the supporting mechanisms required for this young person leading to positive outcomes.

2.7 There is a high level of awareness of safeguarding and risk assessment within the Contraceptive and Sexual Health (CASH) team. Staff are retained in the same clinic allowing them to build trust with the young person, gradually building up a picture of risk and resilience and assisting young people to feel confident to return to the service. Involvement in monthly neighbourhood fieldwork management team meetings of named and designated staff with Childrens Social Care (CSC) ensure risks are assessed and actions taken.

2.8 All CASH staff are aware of the young person's vulnerabilities via a "CASH Safeguarding message alert" pop up on IT screen when a record is opened. In addition, all young people who are known to have safeguarding concerns have an alert on their paper medical record to ensure all staff are aware of additional issues to consider when a young person presents for treatment.

2.9 There is a robust service in place for young people requiring termination of pregnancy covering both physical and emotional aspects of health. UPAG, the unplanned pregnancy service at the City Hospital Campus undertake a pre-assessment session for younger and vulnerable client groups. Counselling is routinely offered, either in house or outsourced to specialist services for clients requiring an increased level of support.

2.10 Adult Substance Misuse staff (Recovery) demonstrate appropriate awareness of the need to identify where service users have children and seek to make checks with social care for any involvement. However, current arrangements to share information between partners are insufficient to ensure that risks are promptly identified and assessed by multi-agency arrangements. Recovery staff do not have access to a social care data base so are unable to make checks as to whether social care are aware of drug use where they identify that their service users have children. Recovery staff contact social care by secure email however there can be a delay in receiving a response to this, meaning further safeguarding enquiries cannot be carried out in a timely fashion.

2.11 Cases we saw at adult mental health (AMH) services indicated a lack of clarity about thresholds for CSC referral and formulation of risk assessment for protection of unborn babies where a parent to be has long standing mental health needs that may impact on the baby. However, in these cases AMH practitioners had recognised the potential risks, and were attempting to ensure that some informal support networks were in place in the absence of a Child protection (CP) assessment or plan. The potential impact of parental mental health needs on children and unborn babies was not consistently articulated in risk assessments and recommendations were not clearly identified to ensure that impact and risks would be appropriately recognised and addressed by others.

2.12 In some cases seen across disciplines with capacity issues, there was a lack of pre-empting and planning ahead for children and young people's needs, and this affected the services' ability to be proactive in identifying future needs. This leads to a reactive, crisis management situation when their needs escalate dramatically.

2.13 In cases seen across the teams, it was unclear if outcomes of CSC referrals were open cases, and many were referred to the "Targeted support team" for support below threshold. We referred a number of cases back for an overview of status as it was unclear to the practitioner what input and support the child was receiving and whether there was clear understanding of the changes that were needed and triggers for escalation. Inter-agency communication could be strengthened to prevent this.

2.14 We recognise the value in the early support offer by the Targeted support team, however we saw ongoing concerns across health that there can be a level of professional optimism in some very complex cases where it was deemed unlikely that this lower level intervention would have a positive impact and reduce safeguarding concerns. This was highlighted in two recent cases that following substance misuse worker intervention, over a lengthy period of time, are now at the legal planning stage. The introduction of the multi-agency consultation forum is a welcome development and if used appropriately should ensure timely, critical challenge and discussions that improve outcomes for children and young people.

"M" is a sexually active young person displaying risk taking behaviour. She is difficult to engage and flagged as a vulnerable person within the CASH system. After non-attendance at a booked clinic, she was followed up by staff and attended a drop in sexual health clinic outside of her usual area, this attendance was noted on the common IT system. Due to further concerns raised at this appointment, she was referred to the complex cases clinic but failed to attend. The accompanying adult who had attended with her was contacted and staff completed a "teenage vulnerable record". In the course of this, information regarding self harm was identified and the CASH nurse advised the young person be taken for emergency consultation at ED. The CASH nurse liaised with acute services to ensure M attended ED and instigated a CAMHS and CSC referral, following up regularly to ensure M was engaging with these services. This acted as an effective mechanism for ensuring all staff were aware there were safeguarding concerns surrounding the young person.

3 Child protection

3.1 Effective paper based processes are in place to ensure that ED staff are aware of children who have been made subject to child protection plans, which is updated on a weekly basis from CSC. Currently, the hospital information system does not electronically flag these alerts or those alerts about children who become looked-after. Whilst the paper list supports safeguarding risk assessment in the acute setting, there is a risk that too much emphasis is placed on the individual practitioner seeking out this information to cross check young people, which may be unrealistic in the busy acute setting. (**Recommendation 3.6**)

3.2 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.

3.3 At times, poor information sharing has impeded some health practitioner's attendance at Initial Child Protection conference (ICPC) meetings. In a number of cases in the school nursing service, notifications of meetings were either not received or given verbally on the day of the meeting in the case of teams who are co-located with CSC staff. In one such case, the minutes of the ICPC had not arrived despite it being 6 months after the meeting. This inhibited health staff's ability to contribute effectively to supporting and monitoring the CP action plan.

3.4 Within a number of services, we saw discrepancies in recording and variable staff understanding of the differences between child in need plan and Child Protection plan. This included children whose records had been incorrectly flagged as child protection when they were child in need and vice versa. This indicates that practitioners are unaware of their roles and responsibilities and cannot discharge their safeguarding duties effectively to optimally support the child or young person.

3.5 Nottinghamshire Healthcare Trust (**NHCT**) management oversight of the quality and responsiveness of work with children on CP plans is limited. NHCT do have a policy that staff prioritise attendance at CP meetings and core groups though staff report that the short notice given impedes routine attendance. Whilst CAMHS and AMH policy supports staff contribution to CP where they are working with a child, the service does not have mechanisms to monitor this and we did not see evidence of contribution to child protection meetings in cases sampled. Managers of these teams do not collect attendance figures or rates of provision of reports. The absence of central hub style arrangements to track requests to attend meetings, means that levels of contribution and attendance cannot be assured, leading to limited information exchange that could enhance support for vulnerable children and young people. (**Recommendation 2.5**)

3.6 We saw a commitment to attend child protection meetings from the adult substance misuse team, in addition to providing a written report to ensure specific information would be correctly recorded. There is some variation in this reporting process that is practitioner specific within the service, therefore the introduction of a standard operating procedure for children on child protection plans across the team would be useful to drive up quality and consistency.

3.7 The Head 2 Head young person's substance misuse team have well embedded arrangements in place to adapt to children's changing needs, particularly those on child protection plans. We saw a consistent standard of engagement and contribution to processes across all cases reviewed, with exemplary work undertaken as part of the ongoing "Face Risk assessment tool" and safeguarding care plan that is routinely updated in the front of all service users records. Practitioners robustly monitor actions and outcomes documented for their own and other health services, with liaison and escalation used appropriately. This commitment to the welfare and wellbeing of often very challenging young people is commendable.

3.8 Overall, GPs are well engaged with safeguarding and child protection arrangements. The success of the GP leads' safeguarding meeting with a high number of practices represented is testament to the ongoing and forward thinking work of the named GP and lead GP for child safeguarding in the CCG. We saw an example where a GP attended CP conferences in her own time. The "signs of safety model" is being piloted across a small number of practices and could be further developed into a report template to provide a detailed contribution to a conference. **(Recommendation 4.2)**

3.9 We heard about frustration in the period of notification given to GPs and other health staff to attend CP meetings and also the choice of location. Work is underway to develop GP contribution, but limited consideration has been given to widening the options to facilitate GP participation in child protection conferences, for example by holding the meetings at GP practices at lunchtimes or the use of video or tele conferencing etc. The work of the lead GP is a real driving force in ensuring GP's are aware of their roles and responsibilities in this area however logistical issues are a barrier to further development.

Child D is known to the Head 2 Head service and is difficult to engage. Child D has complex needs and there is a high level of risk, including parental mental health and domestic violence issues involved in the case. D's substance misuse (SM) worker instigated meetings and comprehensive information gathering to ensure all agencies involved were aware of the impact of stepping down the case to child in need. She also led a co-ordinated approach in case management accounting for the the number of professionals involved. The SM worker was able to advocate for D and ensure their voice was heard, resulting in a continuation of the CP plan and sustained, long term positive outcomes.

4 Looked after children

4.1 Initial Health assessments (IHA's) are undertaken by Consultant Paediatricians and Associate Specialist Paediatricians from the Children in Care team (CIC) with occasional completion by GP's for out of area placements or if the child specifically requests the GP to complete. The experienced paediatricians understand the needs of the child and are adaptable in seeing the child/young person in the setting most appropriate for them. CIC nursing staff also offer flexibility in their appointment times for review health assessments (RHA's) for example working longer days to facilitate after school appointments. Children and young people are also routinely offered a choice in where the appointments take place which encourages engagement on an ongoing basis.

4.2 IHA's for the under 9's, are now predominantly completed in the format as if the child/young person will be placed for adoption. This approach will enhance completeness of the health history on initial and subsequent review health assessments, and will allow the child/young person to have a full picture of their younger years when they are given copies of their health history in later life.

4.3 We did not see the use of strengths and difficulties questionnaires (SDQs) within RHA's, and there was no visible impact of this on RHA and health plans. Opportunities to use SDQ's to allow young people to participate in tracking their own emotional growth are being lost. (**Recommendation 2.6**)

4.4 There is significant variability in the timescales of completion for IHA's and RHA's. Paperwork for health assessments is not always received by health in a timely fashion, and we are aware the key performance indicators have been adjusted to take account of this, along with the introduction of a pre-emptive alert being sent 2 months in advance to request paperwork from CSC.

4.5 GPs are not routinely written to requesting information for the RHA unless the child has an ongoing medical condition. Reliance is placed on the foster carer to inform of any changes to health meaning that valuable information may be lost if the GP is not asked for any up to date information prior to health assessments being undertaken. (**Recommendation 2.7**)

4.6 Clear learning from historical issues within the CIC assessment process has had a significantly positive impact on both the quality of IHAs and RHA's and we saw high levels of evaluation and continual service improvement in place led by the strong designated team in CIC. High priority was given to the voice of the child consistently in all IHA's and RHA's seen.

4.7 Further consideration is needed on the arrangements for children outside the local area with regard to timeliness of RHA and consistency and access to services such as CAMHS. The local system, whereby the same CIC nurse completes the RHA on an annual basis has clear benefits in preventing the RHA's becoming episodic. At present there is an inequity in the system for young people placed out of area, as they are often seen by different professionals from one year to another. This resulted in some plans seen being fragmented and lacking clear actions and outcomes. (**Recommendation 2.8**)

4.8 The new template sent out for out of area assessments will ensure health assessments are completed to a minimum standard. Its implementation in May 2014 means it is too early to assess its impact, however it is envisaged this will drive up the quality of assessment for children and young people who are not seen by the local CIC team.

4.9 The CIC business continuity plan needs further consideration as in one case seen, where the usual paediatrician was on sick leave, the use of a professional outside of the CIC team had a detrimental effect on the quality of the IHA undertaken and plan recorded. (**Recommendation 2.9**)

4.10 The recording of IHA and RHA's on SystmOne using a template acts as a quality assurance check on information taken during assessment. In some IHA cases seen, there was variation in how this information had driven the development of a clear health plan on the electronic notes and further investigation and audit of this, alongside development of an action plan would help to ensure consistency in future. (**Recommendation 2.10**)

4.11 The utilisation of the 'task' tool on SystmOne for communication is common place amongst some professionals and ensures actions from the CIC team are directed to the relevant professionals in a timely fashion.

4.12 Health care summaries provided to care leavers are currently under developed. To date there has been no consultation with young people on options and this is an area for development. (**Recommendation 2.11**)

4.13 Foster carers we spoke to reported they attend reviews but do not receive copies of IHA, RHA or plans. There is also limited information provided to them on family history and the impact of health histories on the children in their care. In one case, carers were given a health chronology after repeated requests but felt it would be beneficial to discuss this information with a medic so they could understand the child better and be more prepared for future. Some stated they felt unsure if the issues they raised at the review meetings are in the health plan as they don't receive a copy. (**Recommendation 2.12**)

4.14 Some foster carers reported barriers in accessing the CIC CAMHS service and felt that, at times a one session consultation could often be all that's needed to diffuse issues and address their concerns. They perceive the current system whereby children in foster care cannot access CAMHS until it has been discussed at a professional meeting results in a bottleneck in the system and therefore delays children and their carers getting the help and support they need. In one case reviewed, this lengthy wait, firstly for the professional meeting and secondly for the CAMHS assessment meant the child has not had any input for a year. In another similar case, the child is now going through the adoption process and whilst still awaiting a CIC CAMHS assessment, it has been suggested to the carer it may be quicker to withdraw the referral and start again after adoption to gain more rapid access to the system. (**Recommendation 2.13**)

4.15 Foster carer training and health forum arrangements are under developed. Aside from the CSC business meetings for foster carers, there isn't any health-related forum for carers at present. Health professionals aren't involved in the CSC business meetings and there are no arrangements for health topics to be covered by guest speakers. Foster carers we spoke to reported that the withdrawal of the health-topic related skills programme has left a significant gap in their training and development. (**Recommendation 2.14**)

4.16 Some foster carers report that, outside the RHA appointments, they feel they have to "chase health services", particularly around the actions on the plan. There is no robust system to ensure timescales for health actions are met and on occasions who is specifically responsible for the action. Care plans we saw identified actions to be completed relevant to the child/young person but frequently document 'ongoing' in the timescale section. Likewise, actions on the care plan are not always reviewed routinely on a regular basis to ensure the actions have been completed. (**Recommendation 2.15**)

4.17 Service user involvement is limited in the CIC team. Foster carers and young people we spoke to are not aware of any arrangements to seek their views about health services and haven't been consulted in the past. This is a missed opportunity to deliver an enhanced, needs driven service and achieve better health outcomes for children and young people in care. (**Recommendation 2.16**)

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 cultural diversity of Nottingham city is recognised across services and we saw the interpreting services being made available to service users. In one case we saw that family members were used and this is not good practice. There is a need to ensure that staff are aware of the potential conflicts in reliance on family.

5.1.2 The use of a single patient information system (SystmOne) across many health disciplines including GPs is an effective information sharing tool about children and young people accessing a range of services. It also enables effective tracking of the frequency and locations of presentations for treatment within Nottingham and surrounding areas. The ability to capture and manage the essential safeguarding information of the single IT system, along with the ability to “task” other professionals and set reminders for follow-up ensures services that are on this system do not miss any actions they are required to do. However this highlights the isolation of some providers who use standalone IT systems and development work to bridge this gap would be beneficial. Lack of IT linkages between GPs/ Walk in centres adversely impact on information sharing and ensuring a full picture of children’s health needs, and we are aware that there is a plan to move onto SystmOne in one Walk in centre in August 2014.

5.1.3 For services using the RIO system (Recovery service, AMH, CAMHS and Head 2 Head), client contacts are not easy to follow in terms of the most recent activity, work or correspondence. This makes it harder to ensure that actions and records of actions are complete, leading to uncertainty if children and young people’s needs are being met consistently and in a timely manner.

5.1.4 Some tightening of safeguarding practice would be supported by the inclusion of additional mandatory fields on electronic records including “accompanied by” as a compulsory item. Within CASH and in other NUH services we visited such as Midwifery and ED, staff made good use of free text boxes on electronic notes to record this and partners details information. However this carries an inherent risk and places emphasis on the skills and experience of the practitioner who understands the importance of including this. A mandatory field box would act as a prompt, and we have been told a number of services are nearing the end of their IT contract so this would seem a pertinent time to look at new developments.

5.1.5 Strong and consistent leadership, alongside long established members of staff in the designated teams and quality roles has had a significantly positive impact on the prioritisation of safeguarding to meet local changing needs. The recent bid accepted for 'fulfilling lives, better start' for ages 0 – 3yrs 11mths covering the 4 most disadvantaged wards in the city aims to address social, emotional development, communication and language and children's nutrition. This is a clear example of leadership showing innovation in evidence based practice to improve health for the most disadvantaged children.

5.1.6 To ensure health visiting services are consistent in their approach to children and their families a standard service framework document has been produced. Changes in health visitor service delivery from being geographical to GP based has taken place following identification by the health visitor service that the previous system was not meeting children and families' needs . This is a positive development allowing increased liaison with GPs. We saw this constant re-evaluation of service as a strong feature in some services we visited, which ensures they are responsive to the changing healthcare needs of service users.

5.1.7 Managers and staff have responded positively to increase the numbers of practitioners within the health visiting service .The huge changes and demands placed on the team to enable effective mentoring of the students are now reaping the benefits due to an increased number of health visitors in practice progressing through the system.

5.1.8 Forward thinking leadership within health visiting and school nursing services act on issues identified by staff. The recruitment of a health visiting immunisation lead to target the 'hard to reach' areas highlights a good understanding of the areas of need to improve poor uptake of immunisations.

5.1.9 In regard to consistency, further work is needed to achieve equity of service and practice within school nursing services across the city and we understand there is work in progress. The introduction of a common school offer for health awareness work, that includes three new health promotion young person posts should also help to achieve this, particularly targeting schools that have been more difficult to engage. We heard from a young person we met about the effectiveness of her school nurse in delivering sexual health awareness in a fun but meaningful manner and the importance of the good relationship that the nurse had established.

5.1.10 All services visited have do not attend (DNA) policies and health practitioners demonstrate an assertive and persistent approach to ensure the continued engagement of both children and adults with services. The NHCT is consulting on a revised DNA policy and safeguarding leads are aware of the need to ensure gaps which have led to SCRs elsewhere are addressed.

5.1.11 Within the acute setting, there is an understanding of the need for combined consultant posts of paediatricians with a specialist interest in ED. This coupled with an increased demand for paediatric ED services has led to management recruiting one new post to target this. In addition new rota systems have been developed to help ensure there are appropriate numbers of nurses on shift to help meet the numbers of children presenting at ED .

5.1.12 In NUH, there is a recognition of the need to monitor safeguarding workloads and ensure midwives continue to maintain their clinical skills when in supportive specialist roles. Due to an increasing workload for the named midwife, two additional midwives have been employed working 50% clinical and 50% to support the role of the named midwife.

5.1.13 Currently oversight of safeguarding referrals in NHCT services is inadequate to ensure that risks to children and young people are being thoroughly considered and properly responded to. The NHCT Local services safeguarding lead no longer has capacity to go out to the Recovery team to undertake supervision and the team manager is trying to set in place alternative arrangements at present.

(Recommendation 2.17)

5.1.14 Within the CASH team, there is good management oversight of the most vulnerable cases as the team manager retains copies of all safeguarding referral forms. This ensures staff are supported and appropriate follow up can be monitored as appropriate.

5.1.15 The named GP and lead GP for child safeguarding provide strong leadership to the cohort of Nottingham City GPs. The named 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. She brings a high level of passion and creative innovative practice to the role including the development of a technology “APP” to house all safeguarding information and contact information on smartphones for ease of access. The development of a public awareness children’s safeguarding programme entitled “Don’t keep Mum” also skills up members of the public in how to describe their safeguarding concerns and make referrals if they have worries. The lead GP provides advice and guidance and is effective in helping GPs understand their roles and responsibilities in relation to children’s safeguarding. This is driving the development of consistent good practice across primary care including initiatives such as the GP Shared Learning Pilot where GP cluster practices can share case based learning on a regular basis.

5.1.16 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 SCRs are now established. Partners have used the SILP review model to good effect. The introduction of the new Safeguarding health overview group to look at the recommendations in SCR's and learning reviews, ensures providers can evidence their actions and ongoing impact over a longer term. This will allow key themes to be identified, leading to good commissioner oversight and identification of any gaps in service provision.

5.1.17 Across a number of services, we saw cases where there was an assumption that other agencies were involved and actioning concerns about the young person. However there is currently a lack of assurance and clarity and we have referred some cases of this nature for a joint health and social care overview. Further analysis of this is required, and we understand thresholds for access to CSC have been ratified during the period of this review. Whilst partner agencies have escalation policies in place, we saw limited evidence of their use or effectiveness in some cases seen. Clearer communication and clarity on the part of both agencies would be beneficial as a learning and development tool for all.

5.2 Governance

5.2.1 Appropriate arrangements are in place to provide NHS Nottingham City with assurance on safeguarding practice.

5.2.2 Governance of safeguarding across NUH is high, with annual audits in place to enable practice to be improved. The range of practice audited in midwifery, including CAF, completion of safeguarding documentation and Substance misuse processes identified learning and development needs and mechanisms have been put in place for service improvement

5.2.3 We saw evidence of the quality of record keeping being improved due to the annual audits being undertaken in both CIC and FNP teams. Any quality concerns raised in this process have action plans developed against them.

5.2.4 The ongoing randomised control trial for Group FNP from early pregnancy to age one shows a willingness to work in new ways and an understanding that the current, historical methodology for FNP work may not always be the most appropriate for all service users.

5.2.5 Within the midwifery service, a variety of electronic and paper based recording systems are in use, leading to significant risk of incomplete information being available to the practitioner. Inconsistency with multiple systems ranging from the two electronic systems (Medway in acute midwifery and System1 in community) which are unable to be linked, alongside paper hand held records and case note records means there is no assurance that midwives are able to access the most up to date information in one format. (**Recommendation 3.7**)

5.2.6 Arrangements are in place in some teams to ensure service users have a visible presence within the service, including parent forums held bi-monthly by the FNP and client representation on a variety of steering groups relating to the development of leaflets. Service users (3 mothers and 1 father) are also on the interview panel for new FNP staff, helping to ensure any new recruits will have the ability to communicate and interact easily and effectively.

5.2.7 The CCG is bringing sufficient rigour to its governance of provider safeguarding activity. Across the review, we have seen evidence of fully supportive and committed individuals within the CCG, with rapid solution focused input to target areas such as the increasing emergence of self-harm cases requiring counselling services in two specific schools. This resulted in immediate funding of temporary measures to address this, with robust evaluation of its outcomes to assess impact and inform future commissioning. This approach is achieving strong outcomes for children and young people and is to be commended.

5.2.8 We have seen high levels of analysis by the CCG of what's working and where the gaps are, with providers encouraged to make business cases to create new roles or modify existing service provision to meet new needs. There is an emphasis on reducing duplication and developing more partnership working to make best use of resources. The CCG is city focused and encourages its partners to be, taking an assertive persistent approach to health needs and achieving best outcomes. It is rapid in its response to changing health needs and trends identified by frontline staff.

5.3 Training and supervision

5.3.1 The well-established lead GP meetings are attended by GPs from across the city and participants told us that they find it informative and that it is helping to drive improved safeguarding practice in primary care. This 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 from a range of agencies and the use of case studies. Protected learning time this year has included information on the local domestic violence initiative.

5.3.2 Across some services we visited, practitioners were contributing to ensuring their supervision arrangements were appropriate to their needs and providing high quality reflective discussion. The specialist CIC nursing team, midwifery and teenage pregnancy workers were actively involved in initiating changes made to the supervision model, to ensure their needs were being met at an appropriate level.

5.3.3 One to one safeguarding supervision for health visitors is well secured and established. The feedback from staff has enabled the supervision model to be re developed to ensure the needs of the staff are met. The health visiting service have been gradually embedding the signs of safety model into their practice since January 2014. There is a clear understanding by the service of the needs for regular safeguarding supervision for new practitioners and we saw good practice observed in the child's documentation when safeguarding supervision has been received. New supervision arrangements are in development for school nurses from September 2014 as revisions are required to embed supervision within the team and maximise its full potential.

5.3.4 Within FNP, a variety of supervision methods are available that are effective for the team and allow the needs of the individual to be met. All staff have completed training in line with intercollegiate guidance. This ensures the FNP team is well supported to allow them to continue to manage the high risk cases within their remit.

5.3.5 NHCT have some way to go to establish robust supervision arrangements. At present, the lack of regular formal safeguarding supervision within the CAMHS and AMH team is a gap that is recognised by the Trust, and we saw a number of cases where the opportunity to reflect on cases with dedicated time with a safeguarding expert advisor would have been beneficial for both the child's outcomes and practitioner skill development. (**Recommendation 2.18**)

5.3.6 Recognising the complexity of their work, staff in the Recovery service undertake level 3 training opportunities relevant to their roles and at a greater frequency than is the trust minimum standard . The NHCT Recovery service manager has undertaken NSPCC 5 day supervision training, and safeguarding is included in all clinical supervision. Supervision notes are held separately by manager and worker but the team have recognised that case supervision notes should be held on the clients' case records and they are working towards this.

5.3.7 The CASH team receive training in accordance with intercollegiate guidance, including both multi-agency training in safeguarding, "protect and respect" child sexual exploitation training from NSPCC in addition to NUH mandatory training. Female genital mutilation (FGM) is not prevalent in Nottingham City however this is also being incorporated into the mandatory level 3 NUH training.

5.3.8 CASH supervision is offered in the most appropriate format to meet the needs of the practitioner at that time. Appropriate safeguarding supervision arrangements are in place within the CASH service on a three monthly group basis with an allocated specialist safeguarding nurse for CASH in addition to three safeguarding champions based within the service. One to one supervision is available with each complex case and safeguarding is also on the regular agenda at general supervision.

5.3.9 Recent training on domestic abuse for ED staff incorporates the latest NICE guidelines. This ensures staff are up to date in their management of these vulnerable children and families and can signpost and treat the child/young person appropriately.

5.3.10 Strong leadership within the ED department has ensured that safeguarding training is now embedded with 99% of all staff being level 3 trained. This training is combined with adults and paediatric ED staff ensuring all practitioners are involved with a think family approach.

5.3.11 An effective support system is in place for ED staff to discuss any safeguarding issues, complex cases or clinical concerns. This 'Roll Call' meeting is held every morning and evening to ensure all staff can access it at shift change points. It acts as a forum for peer support and discussion with safeguarding leads. Formal safeguarding supervision is in place every 3 months for specialist staff.

5.3.12 Training provision and compliance at the appropriate levels across all provider trusts is highly variable. Aside from CASH, Level 3 training in terms of its frequency, content and delivery is not in line with intercollegiate guidelines, particularly with reference to the multiagency element. (**Recommendation 5.1**)

Recommendations

- 1. NHS Nottingham City CCG with Nottingham City Council and Nottingham CityCare Partnership should ensure:**
 - 1.1 That health visiting services implement routine targeted ante-natal visits as part of their core offer
 - 1.2 That plans in health visiting records are SMART with clear outcomes and timescales documented and audited
 - 1.3 That School Nursing services prioritise attendance at GP red card meetings
 - 1.4 That consideration is given to the provision of 24 hour walk in centre facilities as part of the ongoing review into the service
 - 1.5 That the children and young person's services within the Walk in Centre is reviewed urgently, in terms of prioritisation and provision of appropriate facilities

- 2. NHS Nottingham City CCG with Nottingham City Council, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Trust should ensure;**
 - 2.1 That the Adult mental health team provide "signs of relapse" indicators as part of care planning and these are routinely shared with other health professionals involved with the family
 - 2.2 That measures are put in place to strengthen communication and liaison between the Adult mental health team and other health professionals
 - 2.3 That the role of the Paediatric Liaison Health Visitor is reviewed and resourced appropriately to allow oversight of all under 18 presentations in ED
 - 2.4 That an on-call CAMHS crisis team is established within the new CAMHS arrangements
 - 2.5 That the contribution of the CAMHS team to child protection conferences is monitored
 - 2.6 That the use of SDQ information gained from young people and carers is routinely collected and that health plans take account of SDQ findings so that appropriate plans can be put in place to respond to the needs identified

- 2.7 That GPs are routinely asked for information to contribute to Review Health Assessments
- 2.8 That arrangements for children in care placed outside the local area are clarified and secured to ensure children and young people placed out of area do not receive an inequitable service for RHA's
- 2.9 That a business continuity plan is put in place to ensure adhoc staff involved with IHA's and RHA's have appropriate training
- 2.10 That quality assurance checks for both initial and review health assessments are scheduled on an ongoing basis to monitor quality of electronic health plans for children in care
- 2.11 That care leavers are provided with comprehensive, age appropriate health history information such as health passports
- 2.12 That foster carers routinely receive copies of IHAs, RHAs and health plans
- 2.13 That access to the dedicated CAMHS CIC team is made freely available for children, young people and foster carers and access arrangements are regularly monitored to ensure needs are met in a timely way
- 2.14 That the implementation of foster carer training and health forums are considered
- 2.15 That the health care plans within CIC team are SMART, with specific timescales for action and regular oversight by the CIC case holder to prevent drift in cases
- 2.16 That the CIC team introduce service user involvement strategies as part of their ongoing development plan
- 2.17 That safeguarding referral management and supervision oversight arrangements are put in place within the Recovery team
- 2.18 That formal specialist safeguarding supervision arrangements are installed for the CAMHS and AMH teams

3. NHS Nottingham City CCG and Nottingham University Hospitals NHS Trust should ensure;

- 3.1 That the IT system in use within ED services is developed to include mandatory safeguarding fields
- 3.2 That age appropriate waiting facilities for adolescents in ED are developed
- 3.3 That a referral pathway from ED to the Head 2 Head young people Substance misuse service is developed

- 3.4 That a process is implemented to ensure Multi Agency Pregnancy Liaison Group information is routinely uploaded to SystmOne
 - 3.5 That the IT system in use across Midwifery service is developed to include mandatory safeguarding fields
 - 3.6 That electronic flagging of children and young people on child protection plans or who are looked after is implemented on IT systems in ED
 - 3.7 That a single consistent recording system is considered for Midwifery services
- 4. NHS England Area team in partnership with the CCG should ensure;**
- 4.1 That General Practice arrangements for the GP red card meeting are monitored to ensure consistency across the Nottingham City
 - 4.2 That consideration is given to the development of a child protection report template using the Signs of Safety model to enable GP's to provide a consistent contribution to CP conferences
- 5. NHS Nottingham City CCG with Nottingham City Council, Nottinghamshire Healthcare NHS Trust, Nottingham CityCare Partnership and Nottingham University Hospitals NHS Trust should ensure;**
- 5.1 That all providers develop Level 3 safeguarding children's training that is in line with the requirements set out in intercollegiate guidance

Next steps

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

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