

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

Children Looked After and Safeguarding

The role of health services in Devon

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Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	7
What people told us	8
The child's journey	9
Early help	9
Children in need	14
Child protection	20
Looked after children	23
Management	25
Leadership & management	25
Governance	28
Training and supervision	29
Recommendations	31
Next steps	35

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Devon. 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 Area Teams (ATs).

Where the findings relate to children and families in local authority areas other than Devon, 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 76 children and young people.

Context of the review

Most of Devon residents, 81.0% (629,787 residents) are registered with GP practices that are part of the NHS North, East, West Devon Clinical Commissioning Group (NEW Devon CCG). 18.2% (141,506) of Devon residents are registered with GP practices that are part of the NHS South Devon and Torbay CCG. There are some Devon residents that are registered with GP's that are a part of further CCGs but these are much lower in number.

Children and young people make up 21.2% of Devon's population with 5.8% of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in Devon is generally better than the England average. Both the infant mortality rate and the child mortality rate in Devon are comparable to the England average.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly better when compared against the England average. This suggests that there is a low proportion of looked after children within Devon. However, The Child and Maternal Health Observatory (ChiMat) reports that in 2013, the percentage of Devon's children in care with up to date immunisations was significantly worse in comparison to the English average. Immunisation outcomes were variable in Devon, the overall percentage of all Devon's children having MMR vaccinations was similar to the English average and the percentage of children completing other immunisations such as diphtheria, tetanus and polio by aged two was significantly better than the England 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. In terms of hospital admissions, the rate of hospital admissions caused by injuries in two age cohorts (children under 14 years of age and young people between the age of 15 and 24 years) was similar when compared to the England average. With regards to mental health, the rate of hospital admissions for mental health conditions was also not significantly different to the England average. However, the rate of hospital admissions as a result of self-harm in 2012/13 was significantly worse when compared against the England average.

In 2011, the conception rate for under 18 year olds per 1000 females in Devon and the percentage of teenage mothers in 2012/13 was not significantly different when compared to the England average. Both breastfeeding indicators (breastfeeding initiation and breast feeding prevalence at 6-8 weeks after birth) were significantly better than average.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Devon. The average score per child in 2013 was 15.9. This SDQ score is considered to be borderline cause for concern. There has been a slight decrease in the 2013 average score compared to the previous year, however over the last few years the average score has generally remained consistent suggesting that the emotional health of looked after children in the local authority is not improving.

In 2013, the DfE reported that Devon had 435 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). The DfE reported that 75.9% received their annual health assessment which is much lower than the England average of 87.3%. The percentage of looked after children that had their teeth checked by a dentist in Devon (86.2%), was slightly higher than the England average of 82.0%. As at 31 March 2013, there were 55 looked after children who were aged five or younger, of these 72.7% had up to date development assessments, this is much lower than the overall English average of 84.3%.

Devon's Multi Agency Safeguarding Hub (MASH) is a partnership between Devon County Council Children's Social Care, education and youth services; Devon and Cornwall Police, health and the probation service, youth offending team (YOT), early years childcare services (EYCS) and domestic violence services (DVS). Information can be received into the MASH through enquiries from both professionals and the public; following such enquiries relevant information will be sought from partner agencies within the MASH which will then inform decisions about whether the child is at risk of significant harm or may benefit from support from other services. All referrals are subject of triage at point of receipt and not all will be passed into the MASH process. Devon was the first authority to develop a MASH.

The NSPCC published two SCR's relating to Devon in April 2014, one published case was the CNO8 case. There were seven recommendations made following the completion of this review, two of which were specific for GP's. 1. GP practices need to find ways to receive and respond to indicators of risk to children, including incidents of domestic violence. A nominated senior person within every GP practice is to ensure that there is a recognised and effective system within their practice to flag up incidents (including domestic violence) and fulfil their safeguarding responsibilities and 2. A process should be commissioned to enable GP practices to receive police 121A's, reports of domestic violence incidents. The second published case was the CN10 case.

Commissioning and planning of most health services for children are carried out by NEW Devon CCG.

Commissioning arrangements for looked-after children's health are the responsibility of NEW Devon CCG. Designated nurse functions are contracted from Virgin Care, designated doctor functions from Royal Devon and Exeter NHS Foundation Trust (though currently vacant). Virgin Care also provide the looked-after children's health team - operational looked-after children's nurse/s who undertake review health assessments for the over five year old and the health visiting service undertake review health assessments for the under five year olds. At the time of the review initial health assessments (IHAs) were undertaken by paediatricians.

Acute hospital services are provided by North Devon Health Care Trust and Royal Devon and Exeter NHS Foundation Trust.

School nurse services are commissioned by Devon County Council and provided by Virgin Care.

Health visitor services are commissioned by NEW Devon CCG and provided by Virgin Care.

Contraception and sexual health services (CASH) are commissioned by Devon County Council Public Health and provided by North Devon Health Care Trust.

Child substance misuse services are commissioned by Devon County Council Public Health and provided by Addaction (Rise).

Adult substance misuse services are commissioned by Devon County Council Public Health and provided by Addaction (Rise).

Child and Adolescent Mental Health Services (CAMHS) are provided by Virgin Care.

Specialist facilities are provided by Plymouth Community Health CIC and other providers of tier 4 services across the country and commissioned by NHS England specialist commissioning team based in the Bristol office.

Adult mental health services are provided by Devon Partnership NHS Trust

The last inspection of health services for Devon's children took place in June and July 2009 (published in September 2009) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. As an early inspection in the national programme, there were no separate judgements made for health's contribution to children's safeguarding or for the Being Healthy outcome for looked-after children.

Recommendations from that inspection are covered in the lines of enquiry for this review.

The report

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

What people told us

A woman we spoke to on the maternity ward said;

“They’re great, really nice. I chose to come back here even though I’ve moved and have another hospital closer as they know me and I know them well. We’ve been coming here for years”

A foster carer told us;

“Our CIC nurse is lovely, and our foster child responds really positively to her. She’s not intrusive in any way and is sensitive on discussing difficult issues with a teenager”

“I like the opportunity to sit in on part of the RHA so I feel fully informed, however I don’t get copies of it or any health plans.”

“The CIC nurse chases things up for me so it’s really helpful”

A foster carer whose foster child is involved with CAMHS told us;

“Two days before the appointment, CAMHS cancelled it as they became aware that the child was out of area, and there was a query over who would pay. I was devastated when the appointment got cancelled, I was just holding out for that as things were so difficult. The situation has been resolved by the other authority employing a private psychotherapist to work with her. She is now making excellent progress.”

Young people told us;

“CAMHS helped me because I wanted my meetings in my local youth centre rather than in Springfield Court building as I found the building too clinical and it made me panic”

“I feel listened to. The staff have given me enough information and have worked around my needs.”

“My CAMHS worker runs around my college timetable so I can get to sessions easily”

“I have been given the help and support I need. I would like to see referral time’s change for CAMHS as it took me a while to get the support I have now.”

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 The establishment of a robust and accessible multi-agency early help offer is acknowledged by partner agencies across Devon, as an area for development and identified as a priority by the Devon safeguarding children's board (DSCB). The underdevelopment of early help support for young people with emotional needs has contributed to a significant increase in numbers of young people presenting at tier 3 or tier 4 levels, some of whom have not previously accessed services (**Recommendation 3.13**).
- 1.2 Location of the early help team at the MASH is facilitating vulnerable families' increased access to early help support. Health practitioners have told us that over recent months, there has been earlier identification of the need for early help. This is enabling an earlier establishment of a team around the family where there are vulnerable children.
- 1.3 Women in Devon benefit from continuity of care with the same named midwife both ante natally and post natally due to small community teams. Women we spoke to on one of the maternity wards were very positive about the care and support they had received from the service.
- 1.4 In both North Devon Health Care Trust and Royal Devon and Exeter NHS Foundation Trust (RD&E), we found that midwives' initial assessments were comprehensive. Assessments include partner's details including partner's other children, mental health issues, drug use and social factors. However, in North Devon it is not routinely clear when a mother-to-be has contacted the midwife for a booking appointment as there is no formal referral process. This is not recorded on the case notes. It is also not always clear where the booking appointment has taken place which may have relevance for overall assessment of risk (**Recommendation 1.1**).
- 1.5 Midwives are well engaged in the universal parenting programme within children's centres across the county, making a positive contribution to sessions on birth and early feeding. Not all cases we looked at in North Devon demonstrated that this programme had been discussed with parents however and as a result, operational managers cannot assure themselves that all expectant mothers are well informed about this early help support (**Recommendation 2.1**).

- 1.6 Information sharing between midwives and health visitors is supported by the use of the health visitor-midwifery liaison forms which are completed for all mothers to be. However, operationally, communication and information sharing between these services is patchy and not at a consistently robust level across all areas. We found good practice in some areas with regular meetings between health visitors and midwives to discuss cases, facilitated by some co-location. These do not happen in all areas of the county, however, and there is no formalised and agreed approach to this between providers (**Recommendations 1.2 and 3.1**).
- 1.7 Similarly, while co-location of some midwives in GP practices does facilitate ad hoc liaison in those practices, midwives do not routinely access GPs for information on mothers-to-be. As a result, there is a risk that key information held by the GP will not inform the assessment of need and level of risk to the unborn. As a lack of effective inter-agency communication and information sharing can mean families do not receive appropriate early help and is a frequent feature in serious care reviews, this is a gap (**Recommendation 1.2**).
- 1.8 The introduction of the Devon Assessment Framework (DAF) as an alternative early help model to CAF is viewed by practitioners across services as positive. Midwives are beginning to use this as an alternative to referring to MASH and we saw some examples across services where DAF has been effective in supporting families and reducing children's vulnerability.
- 1.9 Health visitors routinely undertake ante-natal home visits as part of the universal programme. These are brought forward in response to identified vulnerabilities or concerns and this helps to secure engagement with parents at an early stage.

- 1.10 When children and young people access acute hospital services at North Devon District Hospital the layout of department means the paediatric waiting area cannot be easily observed by staff. Similarly, at RD&E, the children's play room is well equipped with toys and play equipment, providing an attractive place for children waiting for treatment or accompanying parents who are accessing emergency treatment but is not directly observable by staff or parents unless they are in the room with the children. There is a lockable toilet in the room in which a potential perpetrator could easily conceal themselves, unseen by either parents or staff. Despite notices in the room advising parents to supervise children at all times, this does not always happen and children may spend periods of time in the room unsupervised and unobserved. During our visit, two small children came into the room unaccompanied and were then in the room with three adults unknown to them. Although the room and waiting area is covered by closed circuit television (CCTV), this is monitored by the central security team who are monitoring CCTV across the hospital. ED receptionists are not in a position to observe the waiting or children's room and have no access to CCTV monitors covering the area. This is not on the trust's risk register. This issue presents increased safeguarding risks to children at both sites (**Recommendation 1.3**).
- 1.11 There is a nurse-led walk in centre located at RD&E hospital. All cases are booked in at RD&E ED reception and triaged at ED then directed by the triage nurse to the appropriate service. This is effective in ensuring that children and adults requiring treatment access the appropriate service promptly and under the direction of an appropriately trained practitioner.
- 1.12 Both acute hospitals have robust flagging systems on their electronic records systems which are up-dated regularly. We saw and heard examples of good safeguarding practice in both trusts. At the RD&E and North Devon District Hospital (NDDH), numbers of previous attendances for adults and children are identified on the electronic record system at registration. If a child has presented three times in the last 12 months, this prompts an automatic paediatric liaison referral for follow-up in the community. Clinicians routinely check the details of past attendances to inform their assessment and we saw evidence of this on treatment notes.

Case example: A mother attended North Devon District Hospital ED with her 14 year old daughter after she collapsed in the street.

The mother was highly distressed and staff observed her behaviour as “odd”. Despite being medically fit to leave, the mother appeared reluctant to leave the ED.

The woman disclosed domestic violence with her 18 year old child as the perpetrator

A safeguarding children liaison form (SCLF) was completed, with clear actions requested of children's social care by the nurse completing the form.

The SCLF was checked by the named nurse and the staff member was advised that a MASH enquiry should be completed. The practitioner also made a referral to the independent domestic violence advisor (IDVA).

The SCLF ensures any information or level of concern about a child is recorded and shared with relevant professionals quickly and easily. There was evidence of prompt discussion between the nurse and a senior colleague about their concerns in this case and prompt action was taken to safeguard the woman and the child.

However, the limited use of paper records meant that not all family records could be flagged in this case to alert other practitioners of the domestic violence issue in the family.

- 1.13 Assessment paperwork at NDDH ED aids practitioners’ information gathering and risk assessment for both children and adults who present and was compliant with NICE guidance. Assessment proforma at RD&E ED was very out of date however, referring to children being on the child protection register. Documentation is not compliant with NICE guidance and does not support practitioners sufficiently in their assessment of safeguarding risk through prompts and trigger questions. While cases we reviewed demonstrated sound risk assessment practice by clinicians, there was an over reliance on the knowledge and skills of the clinician to undertake a thorough assessment and to record this through free text recording. In a few cases we reviewed, it was not clear that all risks had been considered or that there had been full probing of the circumstances leading to the injury (**Recommendation 4.1**).

- 1.14 When adults attend the RD&E ED, the assessment proforma does not contain trigger questions to ensure that clinicians routinely ascertain the adult's contact with children or whether any children may be at risk due to the adult's attendance for emergency treatment. We saw a case example where it was not clear from the practitioner's recording that children had been fully considered. Children may be at risk of "hidden harm" from parents or adults in their households where alcohol, domestic violence or substance misuse may be an issue. It is essential therefore, that clinicians undertaking the assessment of an adult attending the ED are well supported through prompts and trigger questions in assessment documentation to assess any risks to children. This helps to ensure that clinicians are constantly mindful of the potential hidden risks to children and routinely demonstrate best safeguarding practice (**Recommendation 4.2**).
- 1.15 There is no routine review of all under 18 presentations at the ED or regular audit of cases in either acute trust which would provide assurance that all safeguarding risks are being routinely identified prior to discharge and neither trust has a paediatric liaison role. In most cases we reviewed at the RD&E and in discussions with clinicians there was evidence that all discharges are signed off by a lead consultant. It is not recorded however, whether this review of every case also considers and verifies whether safeguarding risks have been fully considered. Inclusion of evidence of a review of safeguarding risk assessment in the documentation would further strengthen practice and make governance arrangements more robust (**Recommendation 1.4**).
- 1.16 Young people have access to good quality CASH services operated by North Devon Healthcare. The service is sensitive to the needs and confidentiality of the young people using the service while prioritising their safeguarding responsibilities. Practitioners are clear on the need to share information and alert appropriate services when they identify safeguarding concerns. Risk assessment is robust, with a separate template used for under 16s. Practitioners demonstrated a high level of understanding of cultural issues and are well attuned to the potential for women or girls at risk of female genital mutilation (FGM) or child sexual exploitation (CSE) to attend the service.

2. Children in need

- 2.1 North Devon Healthcare midwifery service has an effective alerting system to inform midwives that there are safeguarding concerns or identified vulnerabilities and the plan of action is easily accessible to practitioners. There are no specialist midwives in the service, however, and midwives in North Devon signpost women to relevant services. This includes the referral of expectant women at risk of domestic violence to an independent domestic violence advisor (IDVA). The post is based in the trust and acts as the maternity representative at the multi-agency risk assessment conference (MARAC) which focuses on families where there are known to be issues of domestic violence. This provision is innovative. In some cases we reviewed however, there was no evidence that the prompt questions about domestic violence had been asked as this was not recorded on the booking in form. It was not clear therefore, that midwives are including consideration of these risks in their assessment and ensuring that all appropriate cases are referred (**Recommendation 2.2**).
- 2.2 Liaison by midwives with the substance misuse service in North Devon is poor. Cases involving substance misuse that we reviewed, demonstrated no evidence that these cases had been signposted appropriately or that there had been appropriate liaison with the substance misuse team (**Recommendation 2.3**).
- 2.3 In the RD&E trust, specialist midwives support community midwifery teams with complex cases and we saw strong evidence of their role in liaising with outside teams to ensure a co-ordinated approach to case management. As a result, vulnerable mothers-to-be are well supported. There is good joint working between the vulnerable women's midwife in RD&E and the RISE adult substance misuse team.
- 2.4 Effective internal systems are in place to record additional vulnerabilities and cases sampled highlighted ongoing risk assessment and updates completed in light of new information. Standard paperwork called appendices 1, 2, 3 are in use to alert for vulnerabilities. All are copied to the named midwife for information. Appendix 1 is the initial concern form, 2 is for updates and 3 is used to record discussion and outcomes of multi-agency meetings. There is some scope to improve Appendix 2 to include an "action plan following update" section although overall the system is sound. The Appendix 3 form acts as an effective way to ensure key actions are recorded following meetings and midwives are clear on their roles and responsibilities. Their use also means that maternity service planning is not held up by any delays in receiving formal initial child protection conference (ICPC), child in need (CIN) and core group meetings.

Case example: *An expectant mother registered pregnancy with the midwife team for RD & E. The booking assessment was comprehensive.*

The yellow safeguarding alerts used on the midwifery documentation provided a very visible prompt to all clinicians that there were concerns about risk, domestic violence and maternal mental health in the patient notes.

The case was discussed at MARAC which the specialist midwife for vulnerable women attends routinely and a MASH enquiry was completed along with the prediction and detection form.

The specialist vulnerable women midwife was involved and undertook a joint visit with the CPN from the adult mental health recovery team. The midwife attended a child protection strategy meeting and ICPC. She pushed for a child protection plan to be put in place when other professionals at the meeting felt that child in need status (CIN) was appropriate. The conference supported the midwife's recommendation and a child protection plan was put in place to protect the unborn.

The continuous analysis and assessment document was well used by professionals to gather thoughts prior to the ICPC however; the service's key risk assessment document (Appendix 3) was missing for the last core group meeting

A clear plan of action was put in place post natally

In this case, not all details were recorded on the notes. For example; the woman requested changes of midwives. The practitioner appropriately sought supervision from the named midwife but this was not recorded. This was a case where the named midwife was able to give a thorough "back story" verbally, however none of it was documented well in the case notes.

- 2.5 Arrangements for a joint meeting between the drug and alcohol worker and the midwife at the 12 week gestation stage, along with the monthly multi-agency "vulnerable babies" meeting are effective in ensuring unborn babies are protected. These arrangements are under continual review by both providers to ensure their effectiveness is maintained and this is good practice.

- 2.6 The cessation of the vulnerable women and babies group in North Devon means there is no longer a forum for multi-agency discussion and information sharing on vulnerable mothers to be and their families. This is a missed opportunity to ensure information is exchanged about families where there is risk and to provide a co-ordinated response to ensuring needs are being met most effectively. The group was well attended by a range of services all of whom have told us of its value (**Recommendation 2.4**).
- 2.7 Maternity discharge planning meetings are held routinely where concerns have been identified. These are well attended by relevant services and are effective in ensuring agreed plans are in place and we have seen and heard a number of case examples. In line with best practice, new-borns at risk of withdrawal due to parental substance misuse are not discharged earlier than 72 hours post natal.
- 2.8 We saw good use of the Family Health Needs Assessment tool in the community health service. This is regularly reviewed and updated by the health visitor and parent together, helping parents to engage with and take ownership of the impact of a range of factors on their children. It supports the practitioner's risk assessment and analysis well. Health visitors routinely assess and evaluate the risks home environments present to children and use creative ways to observe other key areas of the house such as kitchens and child bedrooms when they have concerns. The current proforma does not include questions about home environment as routine which would further strengthen the service's already sound approach to risk assessment and help to engage parents at an early stage should the home environment be of concern to the practitioner (**Recommendation 3.2**).
- 2.9 Women have good access to good quality short-term perinatal mental health support and a clear pathway is established from midwifery services. Midwives undertake comprehensive assessments of the mother-to-be's mental health and the "prediction and detection" tool is used effectively when concerns are identified prompting referral to the specialist perinatal service. Co-location of perinatal mental health workers in the maternity unit in North Devon facilitates this. Midwives are well supported by the service to identify mental health needs early and this is helping to prevent reactive case management. In RD&E we saw close working between the specialist mental health midwife and psychiatrist, perinatal mental health team and adult mental health recovery team workers.

Case example: *There is an effective perinatal mental health pathway in place in Devon involving access to a Consultant Psychiatrist clinic and perinatal mental health workers for women who have history of mental health problems.*

An expectant mother booked with the midwife service. A comprehensive assessment of her mental health needs was undertaken at the time of booking in. The “prediction and detection” tool was used when concerns about her emotional wellbeing were identified.

A perinatal mental health team referral was made and the woman was well supported throughout pregnancy.

The introduction of the team in May 2013 was highly valued, and supports midwives to identify mental health needs early and prevent reactive case management. The team also provide annual mental health updates as part of midwifery mandatory training day. Capacity issues mean that the team is currently unable to work after 28 days post natally but a business case is in place to expand the team to offer this.

- 2.10 There is good co-operative working and communication between health visitors and the perinatal mental health service. This is helping to develop a good level of understanding of mental health issues among health visitors who are benefitting from the regular mental health training the specialist service provides. There is not currently an easily accessible glossary of mental health disorders and diagnoses for health visitors as they encounter new terminology and practitioners are likely to find this useful.
- 2.11 Routine liaison between health visitors and adult substance misuse practitioners when both services are involved with families is less well developed. While professionals do meet at formal child protection and child in need (CIN) meetings, we saw no evidence of regular liaison between practitioners in these services outside of these formal forums. Establishing regular communication to share and validate information in cases where the adult may not always be a reliable source of information would enhance early detection of relapse and strengthen multi-agency working around a vulnerable child and family and support these families more effectively (**Recommendations 3.3 and 5.1**).
- 2.12 Young people’s access into CAMHS services is a long standing challenge and is closely monitored by the provider and commissioners. Acute referrals are seen often on the same day or within 1 week depending on need. There is an expectation that children with non-acute needs will be seen within 6 weeks; achievement of this is variable with performance at 75% of target currently. CAMHS provide a telephone advice service, only, to professionals out of hours; provided 365 days a year. However, staff in both acute hospitals expressed frustration in their difficulties in accessing CAMHS support for children out of hours (**Recommendation 3.13**).

- 2.13 Young people engaged with CAMHS are benefitting from the introduction of the increasing access to psychology therapy programme (IAPT) over the past 18 months. We saw and heard evidence of children benefiting from therapeutic interventions leading to good outcomes for individual children. This included those supported by the CAMHS specialist service for young people who have been sexually abused. The specialist eating disorders service is also achieving good outcomes with only one child with an eating disorder requiring a hospital admission in the past 18 months.
- 2.14 There has been an increased need for tier 4 beds and use of section 136 of the mental health act. As there is not a place of safety young people can only be held under a section 136 in a police cell. Not all young people in crisis or held on a section 136, require a tier 4 in-patient bed. Often young people in crisis are supported in a range of unsuitable places such as acute paediatric wards, their own home or, on rare occasions, residential settings. Clinicians and practitioners in all services work hard to support children in these circumstances but paediatric ward staff are challenged in supporting mentally unwell children effectively while minimising risk and detriment to other children on the ward. Health commissioners are working in partnership to develop appropriate out of hours/ crisis provision and place of safety (**Recommendation 3.14**).
- 2.15 The CAMHS assertive outreach team to be launched in the Autumn will provide an opportunity to reduce admissions to tier 4. Young people nearing crisis will have increased access to intensive support at home and early discharge from tier 4 provision back into the local community will be facilitated. This is a very positive development, modelled on a well-established good practice model.
- 2.16 Where children are currently placed outside the area, often at significant distances, the weekly tier 4 monitoring meeting operating for the past 12 months ensures the service understands the needs and monitors progress of each child ensuring children have a smooth transition back into local services when they are discharged home. While clinicians make use of teleconferencing into care programme approach (CPA) reviews to maintain engagement with the child and parents, children receiving in-patient treatment in remote locations makes it difficult for them to have sufficient contact and support from family. In some cases, this can result in longer in-patient stays. The under provision of T4 beds in the region is recognised by NHS England specialist commissioners.
- 2.17 Practitioners in both emergency departments have a high level of awareness of the risks of children going missing or absconding from the department. Where a child is identified as being at risk of going missing, a record is made of the child's appearance and clothing and we saw case examples which demonstrated this. This is good practice. Due to significant numbers of young people attending the ED with self-harm and mental health needs, the practice is also seen as routine by staff.

- 2.18 The daily presence of the IDVA in the North Devon ED is a positive development and the domestic violence support pathway is robust. Domestic violence is now a mandatory enquiry for all over 16's who present and staff have undertaken additional domestic violence training. Health services across the economy are well engaged with MARAC arrangements with services having identified MARAC lead practitioners.
- 2.19 The named nurse at RD&E has developed an accessible guide based on the threshold tool to support ED practitioners in making a good quality MASH referral. The means of making a MASH referral in both acute trust EDs is challenging when practitioners are working in busy acute hospital settings and the current process does not best support prompt referrals being made. At RD&E and NDDH, the safeguarding team expects to be copied in to the referrals so that they can monitor progress, however due to the referral pathway, this does get forgotten on occasions. This weakens the ability of the safeguarding team to oversee practice. We understand that there are some discussions in hand to explore a "one click" pathway, but the status of any such discussions are not clear as health practitioners at the MASH were not aware of these. This issue has been drawn to the attention of the local authority.
- 2.20 RISE adult substance misuse staff have a flexible approach to appointment times and locations to help facilitate parental access and engagement with the service. Cases seen demonstrate workers support clients effectively to access universal services at children's centres by meeting with the parent at the centre.
- 2.21 In GP practices, we saw evidence of plans in place for joined up working and information sharing for vulnerable families via a multidisciplinary meeting, however there was inconsistency in the frequency and remit of this across the practices. GPs visited had limited awareness of local support services for early help and report they refer everything via MASH but are often unsure of outcomes. Our discussions with them indicated a lack of understanding of thresholds and the differences between CIN, child protection and looked-after children procedures (**Recommendation 7.1**).
- 2.22 School nurses and health visitors are making excellent use of genograms and chronologies which are used routinely across these services. These help practitioners understand family dynamics and identify where safeguarding risks may be presented by members of the wider family network, prompting early referrals for additional support from children's centres and other support services or referrals to MASH.

Case example: *A child with ADHD and family under “immense stress”. Father was working shifts. The school nurse identified the mother with her own health problems being alone for long periods with her child with ADHD and very challenging behaviour, was leading to a potential crisis. A genogram was completed setting out the family relationships which helped the school nurse determine where support and stressors were in the family and focus the priorities.*

The school nurse undertook a joint home visit with a social worker after a MASH enquiry was made for family support

Completed DAF (school nurse lead) for family support and the school nurse acted as the bridge between primary and secondary school as child was year 6 and due to transition to secondary school.

The nurse ensured “Carewise” young carer group involvement for the child to access social support due to the mother’s condition.

A clear action plan was in place and outcomes were being monitored.

The school nurse arranged transport for the child to attend summer school to aid transition to secondary school as the child and family would not be able to access this otherwise.

This case highlighted excellent joint working, planning around the child and family’s needs in order to meet the child’s current and future support needs and minimise the impact of changing schools.

3. Child protection

- 3.1 Health and children's social care had recognised that MASH thresholds were not well understood by health practitioners earlier in the year. The threshold tool has been revised and training on the revised tool has been widespread. Managers were confident that practitioners were clearer on what should be referred to the MASH as a result of the revision and training. The MASH has a feedback line in place for practitioners to leave comments about their experience of MASH in order to inform future improvement.

- 3.2 The threshold tool is being used throughout services and practitioners told us that it is useful. Midwives in both trusts make timely referrals to MASH and referrals we reviewed articulated risk clearly. We also saw a good MASH referral in the RD&E emergency department. This was not the case in all services however. In CASH, health visiting, adult mental health, primary care and the emergency department at RD&E, most MASH referrals did not set out the risk of harm to the child sufficiently clearly and it was not always clear what the reason for the enquiry was. We did not review any MASH referrals/enquiries in CAMHS. There is no quality assurance of MASH enquiries in most provider services although feedback is given by health leads at the MASH on poor quality enquiries. The use of exemplar enquiries to support continuous improvement has not been explored (**Recommendations 3.4, 4.3, 6.1 and 7.2**).
- 3.3 In a number of services, including GP practices, substance misuse and health visiting, records of MASH enquiries are not being consistently retained and this is a clear gap (**Recommendations 3.5, 5.2 and 7.3**).
- 3.4 Practitioners we met with in most services expressed concern at the lack of communication on outcomes of referrals/enquiries and we saw evidence in several services where workers had “chased” MASH for responses and action plans. In contrast, we did see several examples in health visiting records of letters from MASH giving the decision made as a result of the referral. It was not widely understood across the health community that where several services may make a MASH enquiry on the same day about the same child or family, the MASH sends a decision letter only to the sender of the first referral it received.
- 3.5 A multi-agency escalation policy is in place and was recently re-launched by the DSCB. We saw examples of its effective use in CAMHS and midwifery with this latter service telling us that it rarely needed to be invoked. Not all adult mental health practitioners were clear on its use however, and when to bring the Devon Partnership Trust’s safeguarding nurse into case discussions to support use of the escalation protocol (**Recommendation 6.2**).
- 3.6 Health practitioners across all services we visited prioritise attendance at CIN and child protection conferences and in most services there is an expectation that practitioners will submit a report in advance as well as attending. Practitioners told us they welcomed the new proforma introduced for all services. This is facilitating consistency of information, ensuring that key issues are routinely considered by all agencies and conference decisions can be better informed.

- 3.7 CAMHS practitioners told us that they are not always invited to child protection conferences and core groups and we saw a case example of this. Children's social care has a responsibility to ensure relevant services are invited to meetings and receive copies of minutes and plans promptly. However, health practitioners have a responsibility to ensure they know dates of subsequent conferences and core groups and that they have copies of child protection plans to inform their work with the parent or child. There is no joint work underway currently to explore alternative ways of ensuring the invitation process is robust (**Recommendation 3.15**).
- 3.8 Devon Partnership NHS Trust adult mental health services are making progress towards developing a Think Family model of service. Although this is not yet embedded, progress towards this is evident and we saw a number of case examples where practitioners were demonstrably prioritising the safety of children while effectively supporting the parent's mental health needs. For the most part, reports shared with other professionals make use of accessible rather than clinical language. However, care plans are not always up to date and in common with some other services, we did not see evidence of detailed service plans or agreements made with the client to under-pin the child protection plan. Child protection plans we saw encompassed broad expectations from a health service, such as "on-going engagement" it is essential therefore, that practitioners establish clearly with the client what this means to best facilitate the service intervention and to support optimum decision making at child protection conferences (**Recommendation 6.3**).
- 3.9 The Appendix 3 form used by RD&E midwifery service acts as an effective way for midwives to ensure key actions are recorded following initial child protection case conferences (ICPC), Child in Need and core group meetings and that midwives are clear on their roles and responsibilities. Their effective use also means service planning is not held up by any delays in receiving child protection plans or minutes of formal meetings.

Case example: *A mother with mental health issues registered her pregnancy with RD& E midwives. The unborn was subject to a child protection plan. Appendices 1-3 were completed setting out the concerns and actions professionals and the woman needed to take to minimise risk.*

A meeting was held with the specialist midwife for vulnerable women and the perinatal mental health team.

There was clear mental health planning at 32 week stage for the birth which included the perinatal mental health worker, Midwife and the woman's community psychiatric nurse (CPN).

MASH enquiry was made, and the midwife chased for a follow up response.

4. Looked after children

- 4.1 Operationally, the children in care (CIC) health nurse team provide a good support service to looked-after children. Performance on the timeliness of initial health assessments (IHAs) is improving and most we reviewed were completed within timescales. However, the quality of initial health assessments varies across the different areas of the county. Of those IHAs we reviewed, the best quality were those undertaken by paediatricians in North Devon. Some IHA's seen were not sufficiently outcome focused. Plans on some were not SMART and lacked measurable goals and accountabilities. Health needs identified in the assessment were not always drawn through and addressed within the health plan leading to risk that some looked-after children's health needs may not be met appropriately. IHAs generally lacked birth and parental health histories. If this information is not captured at the point at which the child comes into care and follows the child through to the point they leave care, this can have a long-term detrimental impact as they enter adulthood (**Recommendation 3.6**).
- 4.2 There is no quality assurance process in place in relation to initial health assessments and the service at this level lacks leadership and co-ordination. Paediatricians undertaking IHAs are not working to a defined and agreed standard across the county and have not received specific training for the role (**Recommendation 3.6**).
- 4.3 Performance on the timeliness of review health assessments has improved and young people have a greater level of choice about where review health assessments (RHAs) take place due to the increased capacity in the children in care nursing team. This has also enabled children in care nurses to take on all RHA's for the over 5's from the school nursing service. The quality of RHAs undertaken by the children in care nurses is very good and significantly improved over those undertaken under previous arrangements. The voice and personality of the child was reflected well in RHAs although this was an area for development in relation to IHAs.
- 4.4 The team has introduced a number of positive developments to help children and young people engage with their health; these include the "Your Children in Care Packs" for older and younger children and the health assessment appointment card. This makes good use of easi-read symbols specifically to help looked-after children with learning disability engage with the service.

Case example: a 17 year old looked-after young person with ADHD. Accommodated in a residential college due to “acute stress at home”. The young person had significant weight issues but refused to undertake diabetes tests due to his phobia/level of understanding.

The CIC nurse worked with the young person over 6 weeks to allay his fears and developed visual resources to help him understanding the diabetes test process and healthy eating. As a result, the young person then accessed the diagnostic tests. The nurse also worked with staff in the college to implement dietary changes

The CIC nurse advocated for the young person when he wanted ADHD medication changes as he felt CAMHS were not listening to him when he raised concerns about his feelings and changes in his behaviour.

The nurse arranged an early CAMHS follow-up appointment and reiterated the young person’s behavioural concerns to get his medication reviewed.

- 4.5 Plans developed from RHAs were not consistently SMART, with some case examples having loose timescales and lacking overarching health objectives but overall, the quality of health plans is improving under the guidance of the lead nurse. Although CIC nurses are expected to evaluate progress on the plan at the subsequent assessments, it was not always clear from records of RHAs how effectively actions to meet identified health needs had been followed up and monitored. The introduction of the benchmarking tool used in peer review helps ensure consistent good quality of RHAs, although this is not recorded on the case record. We are aware that the increase in children in care nurse capacity is not permanently funded at present.
- 4.6 Currently strengths and difficulties questionnaires are only completed by foster carers and there is no triangulation between foster carer, young person and education. We did not see evidence of use of the SDQ in health assessments. Opportunities for greater use of these with young people to help them engage with their health and emotional wellbeing journey are being considered but have not yet been introduced (**Recommendation 3.7**).
- 4.7 No specialist service or fast track pathways are in place for looked-after children to access CASH, CAMHS, substance misuse or pregnancy support. Currently looked-after children are signposted to access generic services. (**Recommendation 3.8**).

- 4.8 The specialist CAMHS service for looked after children, called Service around the Child, fast track children in care when there is a risk of placement breakdown. They do not have a waiting list and during the hours of 9-5 hours, young people are seen immediately. This is changing and support to young people extended, as they are now working in partnership with the new wrap around service for looked after children which operates out of hours. CAMHS referral criteria does not exclude young people in unstable placements although we found some mis-perception from foster carers and among practitioners that CAMHS do not support looked-after children unless they are in stable placements. A task and finish group has been established to work on improving communication and stakeholder understanding regarding CAMHS access
- 4.9 GPs are asked to contribute information to the child's health review and some do. Performance on this is monitored through the team's benchmarking tool giving scope to develop use of this data through the annual report and governance arrangements to increase GP contribution to the health of looked-after children.
- 4.10 Health support to care leavers is underdeveloped and is being worked on by the health team, with consideration of good practice in other areas. Care leavers receive an up to date copy of their immunisations and their health plan but do not receive a health passport with a full health history (**Recommendation 3.9**).
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Management

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

5.1 Leadership and management

- 5.1.1 Partnership working is improving although there is local recognition across agencies that this is work in progress. Partnership working between the CCG and NHS England area team is progressing well. The designated nurse meets regularly with the Area Team Assistant Director of Nursing and Patient Experience.
- 5.1.2 Most health agencies are well engaged with the Devon safeguarding children's board (DSCB), although it has been difficult for North Devon Health care trust to maintain stable attendance and the trust has yet to report its progress on the delivery of the DSCB early help strategy in line with other partners (**Recommendation 2.5**).

- 5.1.3 The chair of the DSCB is very active in engaging with health agencies to support their safeguarding improvement agenda and in working with partner agencies on areas where there are recognised challenges such as young people with mental health needs being cared for on the paediatric ward. The chair of the DSCB regularly walks the child's journey through health services and has set a clear agenda for the agencies engaged with the DSCB to develop the early help offer and improve the effectiveness of multi-agency safeguarding practice. The board is in discussions with providers on how to increase their participation in multi-agency training. This is an area for development that we identified in a number of services.
- 5.1.4 Involvement of health in MASH decision making is being strengthened. Additionally, increased health capacity and recruitment of an adult mental health worker based in the MASH will facilitate effective communication and information sharing; recourse to clinical adult mental health expertise will be more prompt and agencies are confident that decision-making will be enhanced.
- 5.1.5 Provision of the looked-after children health steering group to oversee progress towards a whole system approach to meeting the health needs of looked-after child, is positive. However, non-alignment of data means that performance management and monitoring of the overall performance is made more difficult. As the system and processes currently work, it is difficult to track a child through different areas of Devon when they change placements and move areas. This is a problem for both health and children's social care without a centralised pathway. The work of the children in care nurse team has increased the quality and consistency of assessment and health planning but there is more to do to ensure a robust, consistent and quality assured service for IHAs. The absence of a strong designated doctor lead has meant progress in this aspect of the service has been slow. Increasing the role's capacity by 50% is positive, enabling the new designated doctor to discharge the responsibilities of the role fully (**Recommendation 3.10**).
- 5.1.6 The absence of a designated doctor in New Devon CCG has reduced the strength of clinical leadership. Vacant named nurse posts in provider services have made delivery of improvements in health's safeguarding arrangements more challenging and impeded progress. Also, Devon has never had a named GP. The lack of this key leadership role has made securing strong primary care engagement with safeguarding arrangements more challenging. While we saw some good participation in child protection procedures by a few individual GPs, these are a minority and this remains an area for development. The agreed provision of a named primary care lead for each of the local authority areas covered by New Devon CCG is a positive development and will strengthen leadership; however the date of implementation was unclear at the time of the review (**Recommendation 7.1**).

- 5.1.7 The designated safeguarding nurse is bringing good leadership across the health economy; is well engaged with the DSCB and NHS England and well regarded. But with responsibility for adult and children's safeguarding across a wide and complex health economy and comprised of different local authorities, her capacity to deliver on all aspects of the role is significantly stretched and this is reducing the role's impact across an economy and partnership with a considerable improvement agenda (**Recommendation 8.1**).
- 5.1.8 Safeguarding infrastructures across the health community are also under significant pressure. We saw areas for development or the opportunity to strengthen the safeguarding of children in all services but the capacity for named nurses or safeguarding leads to implement or oversee improvements is very limited. This is particularly the case in North Devon and RD&E hospitals and in Virgin Care. For Virgin Care the recently agreed funding by the CCG to enable a dedicated full time health post to be located in the MASH will release capacity back to the safeguarding team who have been covering this gap. This will facilitate the Virgin Care safeguarding team in working with operational managers to ensure practice and performance management processes are robust; working with children's social care to ensure effective channelling of invitations to CAMHS practitioners to attend key child protection meetings. The recent capacity pressures in the safeguarding team have led to a reduction in the supervision offer to practitioners moving from 1:1 to group sessions. Some practitioners told us they felt this was less effective and that they now feel less well supported. There is no Devon focused named doctor role in Virgin Care. The Virgin Care named doctor for safeguarding children, a consultant paediatrician (based in Surrey), provides the role across the two counties and is available for telephone consultation and advice. However, the absence of a Devon based named doctor does not facilitate the development of a strong local multi-agency designated and named professional interface and network and warrants further consideration (**Recommendations 2.6, 3.11 and 4.4**).
- 5.1.9 School nurses work very autonomously in their patch, with limited leadership and managerial oversight apart from their health visitor team lead. They rarely meet as a whole area school nurse team and some members of the same team only met for the first time during this review. There are inconsistencies in service delivery and service development is hampered as staff are unable to share good practice and develop the service as a team (**Recommendation 3.12**).
- 5.1.10 Devon Partnership NHS Trust is making positive progress on establishing a Think Family model. As part of the targeted families (Devon's Troubled Families initiative) adult mental health has four practitioners based in multi-agency teams facilitating effective multi-agency working to support highly vulnerable children and families.

5.1.11 We heard about cases of children held in police custody under section 136 of the Mental Health Act spending significant periods of time in police cells awaiting CAMHS assessment and of a child placed in a residential children's home while a suitable T4 placement was identified. This type of situation has affected fewer than 10 children per year but strategic managers across health and children's social care services recognise the significant impact on these children. There has been a significant impact from the closure of the T4 provision in Somerset. The unit is due for re-opening in Autumn, delays have resulted in difficulties in recruiting appropriately trained staff. Children from Devon have been placed in Manchester, Scotland and Norfolk. Partners are working with Plymouth and NHS England special commissioning on this issue.

5.2 Governance

5.2.1 Internal governance in both North Devon trust and RD&E midwifery service is underdeveloped and an effective safeguarding practice and performance monitoring process is not in place in either service. The named midwife in North Devon maintains a database of all women identified as vulnerable which is updated when new information comes to light. While this is positive, ensuring safeguarding concerns are logged centrally, its use in facilitating safeguarding audit for outcomes and as part of an effective supervision model has not been explored. Record management and recording practice is also not robust in both trusts' services. Not all practitioner contacts, activity; and discussions of cases with managers and supervisors are recorded. Case records and safeguarding documentation is not routinely audited or quality assured. The designated nurse has not had the capacity to give focused support to these services to ensure best practice is embedded and effective internal governance is in place (**Recommendations 1.5 and 8.1**).

5.2.2 North Devon District Hospital uses paper based records only, which were difficult to follow and at times disorganised, with not all contacts recorded comprehensively. We understand that North Devon Trust has an action plan that they will be fully on electronic recording by the end of 2015. Use of paper records and limited IT systems across a number of health services, particularly in a geographically large county where many practitioners are deployed in rural areas is impeding rapid and effective information sharing between agencies and within services. There is a risk therefore that information regarding some vulnerable children and families may not be adequately or promptly shared to ensure effective multi-agency support.

- 5.2.3 While practitioners in the RD&E routinely sign their treatment records, some handwriting on case treatment records was illegible making it impossible for supervisory practitioners or safeguarding leads to undertake any effective review of clinical judgements or safeguarding practice through the treatment record (**Recommendation 4.5**).
- 5.2.4 The service provider for adult substance misuse, Addaction, has recently taken over the service and has a strong Think Family approach although it will take time to ensure a consistent and embedded approach to this across the county. The development of a multiagency protocol to support joint work between RISE workers and children's social care staff will also enhance the service provided to families with additional needs. However this innovative practice appears to have stalled due to barriers between agencies at present. It is also important for effective communication and liaison with other health services such as health visiting to become established as routine practice across the county.
- 5.2.5 We saw good record keeping and recording practice in health visiting and school nurse services. Case records set out comprehensive observational details, analysis of risks and the practitioner plan for future action. Practitioners told us they feel their practice is well supported by the new model and that it is helping to drive continuous improvement in safeguarding practice. Operational managers are regularly auditing community health records as part of their managerial oversight of performance and practice as demonstrated through case recording.
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5.3 Training and supervision

- 5.3.1 While school nurses and health visitors routinely attend DSCB multi-agency safeguarding training as part of their level 3, a number of providers, including North Devon Healthcare and RD&E trust provide in-house, single agency training only. At RD&E, compliance with in house mandatory training to level 3 is good at above 80%, however this is single agency training and practitioners do not have routine opportunities for multi-agency training. We understand that the trust was accessing multi-agency training but withdrew from this due to courses being cancelled and difficulty in releasing staff. We regard multi-agency training as an essential component for staff operating at this level of competency to be fully effective. This is an area for development for the partnership. This is not in line with guidance and best practice and practitioners such as midwives and ED clinicians are not fully equipped to discharge their responsibilities in an increasingly complex safeguarding environment without having the opportunity to learn alongside professionals from other agencies. This issue has been drawn to the attention of the local authority and DSCB (**Recommendations 4.6 and 8.2**).

- 5.3.2 Supervision arrangements in both midwifery services we visited are under developed and not compliant with statutory guidance. Ad hoc supervision for frontline midwives is readily available by phone and email from both the named midwife and team leader and this is valued and an important strand of supervision arrangements. However this supervision is not formally recorded or audited and frontline midwives do not have regular planned and formalised supervision as set out in statutory guidance (**Recommendation 1.5**).
- 5.3.3 Safeguarding supervision arrangements are robust for emergency department staff at North Devon District Hospital. Practitioners in the RD&E ED have good recourse to ad hoc safeguarding advice and supervision if they request it and reflective and debriefing forums are convened in response to specific incidents or events. These are valued by staff who told us that they find this very supportive. The trust's safeguarding team and particularly the named nurse is accessible; giving sound safeguarding advice and guidance. However, these current supervision arrangements are not compliant with statutory guidance and staff do not have the opportunity for regular, planned and recorded supervision to support their practice (**Recommendation 4.7**).
- 5.3.4 The ED at RD&E operates over a 24 hour period, seven days per week. There is a paediatric trained nurse on each shift and a number of the senior nurses are dual trained. This ensures that children have good and prompt access to appropriately qualified and trained staff and ensures a high level of paediatric expertise is provided at all times. Staff are given opportunities to work in other paediatric services within the trust as supernumeraries in order to give them experience of working with children at different life and developmental stages. This is a positive strategy to maintain good levels of paediatric expertise and to build staff confidence and experience in a supportive way.
- 5.3.5 Female genital mutilation (FGM) is not deemed to be prevalent in Devon. While the RD&E hospital has not had any identified cases of FGM, there have been cases of women at risk of "honour" harm. The hospital has an effective protocol in place to guide staff in ensuring protection and confidentiality of these women. As inspectors, we are increasingly seeing cases of women with FGM using maternity services across the country. It is increasingly important therefore that acute trusts and other health providers have robust FGM policies and knowledgeable staff so that prompt and appropriate action is taken to protect women and new-borns at risk of this abuse as well as older female children who may become at risk. Clinicians also need to be aware of how to provide appropriate clinical support to expectant women who have been victims of mutilation as this can significantly impede normal childbirth. Some midwifery staff have accessed training on this as part of a CSE session however the issues are complex and dedicated training on FGM for this cohort of practitioners is underdeveloped (**Recommendation 1.6**).

- 5.3.6 There is good succession planning in the ED at RD&E whereby the lead nurse practitioner who is dual trained and who leads on MARAC, is mentoring and coaching a more junior nurse to develop knowledge and skill in the area of domestic violence and MARAC procedures.

Recommendations

- 1. NEW Devon CCG, Royal Devon and Exeter NHS Foundation Trust and North Devon Health Care Trust should:**
 - 1.1 Ensure that record keeping and recording practice is robust across services and subject to routine regular management monitoring.
 - 1.2 Ensure that communication and information sharing between midwives and health visitors and general practice is consistent and robust countywide to facilitate the provision of prompt and effective support to vulnerable families.
 - 1.3 Review the physical layout and arrangements for staff oversight and observation of children's waiting and play areas in the emergency departments to ensure that safeguarding risks to children are minimised.
 - 1.4 Ensure that robust governance arrangements are in place to provide operational managers and the trusts' boards with assurance that all safeguarding risks are being routinely identified prior to discharge from the emergency departments.
 - 1.5 Ensure midwifery practice is subject to effective supervision and governance arrangements ensuring consistency of service delivery and continuous improvement.
 - 1.6 Ensure that practitioners are sufficiently knowledgeable about female genital mutilation to provide appropriate clinical and safeguarding support to women and vulnerable children.

- 2. NEW Devon CCG and North Devon Health Care Trust should:**
 - 2.1 Ensure that midwives routinely discuss the universal parenting programme with expectant parents and that this is evidenced in the patient record.
 - 2.2 Ensure that midwives routinely consider domestic violence in their assessments demonstrating this through the patient record and refer cases to appropriate support services.
 - 2.3 Ensure that midwives share information and communicate effectively with the substance misuse service, making referrals as appropriate.

- 2.4 Establish a multi-agency forum which meets regularly to discuss vulnerable mothers to be and their families in order to provide a co-ordinated response, ensuring needs are being met effectively.
 - 2.5 Ensure that the trust is fully engaged with the DSCB and its work streams.
 - 2.6 Ensure there is sufficient named nurse capacity to ensure that the improvement and governance of safeguarding arrangements is robust and practitioners are well supported
- 3. NEW Devon CCG, working with Devon County Council Public Health, and Virgin Care should:**
- 3.1 Ensure that communication and information sharing between health visitors and midwives is consistent and robust countywide to facilitate the provision of prompt and effective support to vulnerable families.
 - 3.2 Review the Family Health Needs Assessment tool to include assessment of the home environment in order that any areas of concern of potential risk to the health and wellbeing of the child are routinely identified and addressed at an early stage of the practitioner's engagement with the family.
 - 3.3 Where practitioners are working with families where there are identified alcohol and/or substance misuse issues, ensure direct liaison and information sharing with adult service workers is routine practice outwith formal child protection and CIN forums.
 - 3.4 Ensure that where safeguarding concerns have been identified, enquiries/referrals to the MASH set out the practitioner's assessment of risk of harm to the child or young person and what response is expected clearly to best inform children's social care decision making; subject to regular quality assurance.
 - 3.5 Take steps to ensure that records of MASH enquiries made by practitioners are retained to provide an audit trail and opportunity for quality assurance to help drive continuous improvement.
 - 3.6 Ensure that initial health assessments are of a consistent high quality setting out parental health histories wherever possible; with health plans that are outcomes focused and subject to robust quality assurance.
 - 3.7 Ensure that strengths and difficulties questionnaires routinely inform RHAs for children who are looked after and that, where possible, young people have the opportunity to use the SDQ to explore their personal emotional growth.
 - 3.8 Work with partners to ensure looked-after children and young people have good access to CASH, CAMHS and other specialist health support services.

- 3.9 Ensure that care leavers are provided with a comprehensive health history and health passport with personalised information to best support their health and wellbeing as they enter adulthood.
 - 3.10 Ensure effective whole systems governance and leadership arrangements are in place in order to ensure continuous improvement in performance on meeting the health needs of looked-after children.
 - 3.11 Ensure there is sufficient named doctor and nurse capacity to ensure that the improvement and governance of safeguarding arrangements is robust and practitioners are well supported.
 - 3.12 Ensure effective leadership and operational governance in order that frontline practice is of a consistent standard across school nurses teams countywide.
 - 3.13 Ensure that young people experiencing mental health issues have prompt access to CAMHS support at all times, including outside of normal working hours.
 - 3.14 Work with partners to ensure that young people in mental health crisis and needing a place of safety or awaiting in-patient mental health treatment and who cannot be supported at home, are cared for in appropriate environments supported by appropriately trained staff.
 - 3.15 Work with children's social care to ensure that mental health practitioners are routinely invited to child protection and CIN meetings and that these notification pathways work effectively.
- 4. NEW Devon CCG and Royal Devon and Exeter NHS Foundation Trust should;**
- 4.1 Ensure that assessment documentation in use for paediatric ED cases is compliant with NICE guidance, supporting practitioners to make comprehensive assessments of safeguarding risks to children who present for treatment.
 - 4.2 Ensure that assessment documentation in use for adults attending the ED encompasses prompts and trigger questions to identify any potential for hidden harm to children and young people.
 - 4.3 Ensure that where safeguarding concerns have been identified, enquiries/referrals to the MASH set out the practitioner's assessment of risk of harm to the child or young person and what response is expected clearly to best inform children's social care decision making; subject to regular quality assurance.

- 4.4 Ensure there is sufficient named nurse capacity to ensure that the improvement and governance of safeguarding arrangements is robust and practitioners are well supported.
- 4.5 Ensure that treatment records in the emergency department provide a clear and auditable record of clinical judgement and safeguarding practice by clinicians.
- 4.6 Ensure that practitioners have opportunities to undertake level 3 safeguarding training in a multi-agency forum.
- 4.7 Establish robust safeguarding supervision arrangements in line with statutory guidance giving practitioners the opportunity for regular, planned and recorded supervision to support their practice.

5. Addaction (Rise) should:

- 5.1 Where practitioners are working with families where there are identified alcohol and/or substance misuse issues, ensure direct liaison and information sharing with health visitors and other health professionals is routine practice outwith formal child protection and CIN forums.
- 5.2 Ensure that records of MASH enquiries made by practitioners are retained to provide an audit trail and opportunity for quality assurance to help drive continuous improvement.

6. NEW Devon CCG and Devon Partnership NHS Trust should:

- 6.1 Ensure that where safeguarding concerns have been identified, enquiries/referrals to the MASH set out the practitioner's assessment of risk of harm to the child or young person and what response is expected clearly to best inform children's social care decision making; subject to regular quality assurance.
- 6.2 Ensure that all practitioners have a good understanding of the escalation policy and when to invoke it.
- 6.3 Ensure that service intervention is underpinned by robust, current and measurable care plans particularly in cases where there is a child subject to a CIN or child protection plan in order to best monitor progress and support optimum decision making at child protection conferences and CIN reviews.

7. NEW Devon CCG with NHS England should:

- 7.1 Ensure that there is a good understanding of child in need, child protection and looked-after child procedures and processes among general practitioners countywide and that they are well engaged with arrangements.

- 7.2 Ensure that where safeguarding concerns have been identified, enquiries/referrals to the MASH set out the practitioner's assessment of risk of harm to the child or young person and what response is expected clearly to best inform children's social care decision making; subject to regular quality assurance.
- 7.3 Take steps to ensure that records of MASH enquiries made by general practice are retained to provide an audit trail and opportunity for quality assurance to help drive continuous improvement.

8. NEW Devon CCG should:

- 8.1 Review the role and capacity of the designated nurse for safeguarding to ensure the delivery of safeguarding improvements and routine governance of adult and child safeguarding performance is well supported.
- 8.2 Work with the Devon safeguarding children's board to develop opportunities for health practitioners across the economy to undertake level 3 safeguarding training in a multi-agency forum.

Next steps

An action plan addressing the recommendations above is required from NEW Devon 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.