

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

# Children Looked After and Safeguarding

## The role of health services in Cornwall

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<b>Provider services included:</b>	Royal Cornwall Hospitals NHS Trust Peninsula Community Healthcare Trust Cornwall Partnership NHS Foundation Trust Addaction GP practices
<b>CCGs included:</b>	NHS Kernow
<b>NHS England area:</b>	South of England
<b>CQC region:</b>	South
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Cornwall. 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 NHS England Area Teams (LATs).

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

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## About the review

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

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

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 116 children and young people.

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## Context of the review

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*Most of Cornwall residents, 99.5% (552,052 residents) are registered with GP practices that are part of the NHS Kernow Clinical Commissioning Group (CCG). There are some Cornwall residents that are registered with GPs that are a part of further CCGs but these are much lower in number.*

*The current 2014 (refreshed March 2014) Cornwall Unitary Authority (UA) and the Isles of Scilly UA Child and Maternal Health Observatory (ChiMat) profile identifies that children and young people make up 21.6% of Cornwall and Isles of Scilly population, with 5.3% of school age children being from a minority ethnic group.*

*On the whole, the health and well-being of children in Cornwall and Isles of Scilly is generally mixed when compared against the England average. The infant and child mortality rates are similar to the England rates.*

*The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly better than the England average. This also corresponds with Cornwall and Isles of Scilly having a significantly better percentage of looked after children having up to date immunisations when compared to the England average.*

*ChiMat reports that in 2013, the overall percentage of all Cornwall and Isles of Scilly children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was not significantly different when compared against the England average.*

*The indicator for the rate of ED attendances for children under four years of age in 2011/12, was significantly better when compared to the England average rate. The rate of hospital admissions caused by injuries for children under 14 years of age was not significantly different compared to the England average. However, the rate of hospital admissions caused by injuries for young people between the age of 15 and 24 years was significantly worse when compared to the England average.*

*The rate of hospital admissions for mental health conditions was not significantly different to the England average in 2012/13. The rates of hospital admissions as a result of self-harm in same time period was significantly worse than the England average.*

*In 2011, the conception rate for under 18 year olds per 1000 females was similar to the England average. In 2012/13 the percentage of teenage mothers was significantly worse when compared to the English average. Breastfeeding indicators were mixed. The breastfeeding initiation indicator was significantly better when compared to English averages and the breastfeeding prevalence at 6-8 weeks after birth indicator was recorded as being similar to the England average.*

*Further indicators that were significantly worse than the England average include the 2010/13 rate of hospital admissions due to alcohol specific conditions; the 2010/13 rate of hospital admissions due to substance misuse (15-24 years) and acute sexually transmitted infections (including chlamydia) in 2012.*

*A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Cornwall. The average score per child in 2014 was 14.6. This DfE score is slightly greater than the England average of 13.9 and is considered to be borderline cause for concern. The average score in Cornwall over the last two years has remained stable.*

*In 2014, the DfE reported that Cornwall had 295 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 91.5% (270) of these children received their annual health assessments. This percentage is greater than the England average of 88.4%. The percentage of looked after children that had their teeth checked by a dentist in Cornwall was 76.3% (225) which is much lower than the England average of 84.4%. As at 31<sup>st</sup> March 2014, there were 15 looked after children who were aged five or younger, the DfE reported that all of these looked after children had up to date development assessments.*

*Commissioning and planning of most health services for children are carried out by NHS Kernow.*

*Commissioning arrangements for looked-after children's health are the responsibility of NHS Kernow, NHS England and the looked-after children's health team; designated roles and operational looked-after children's nurse/s, are provided by Royal Cornwall Hospitals NHS Trust (RCHT).*

*Acute hospital services are provided by RCHT and Derriford Hospitals. Derriford Hospital was not included in this review. Royal Cornwall Hospital, also known as Treliske Hospital, is the principal provider of acute care services in the county of Cornwall. It serves a population of around 450,000 people, a figure often doubled by holidaymakers during the busiest times of the year. Royal Cornwall Hospital (Treliske) provides a 24 hours Emergency Department and The Princess Alexandra Wing (PAW) offers 24 hour low and high risk maternity care including neonatal services. RCHT's children's community therapy service provides child physiotherapy, child dietician services and child occupational therapy (occupational therapy for children in the north and east of Cornwall are provided by an alternative provider). The trust's paediatric community service comprises a team of community paediatricians that work specifically with children with individual needs across the county. The trust also has teaching hospitals status as part of the Peninsula College of Medicine and Dentistry (PCMD).*

*Peninsula Community Health delivers NHS adult community health services in Cornwall and Isles of Scilly. PCH also provides a wide range of community health services across Cornwall and Isles of Scilly including community hospitals, Minor Injuries Units (MIU) which serve children and young people aged under 18, district nurses, community matrons and a specialist palliative care service.*

*The Cornwall Partnership Foundation Trust (CPFT) provides the Cornwall health visitor and family nurse partnership (FNP) service, both of which are currently commissioned by NHS Kernow, and youth offending service specialist nurses.*

*Cornwall Partnership NHS Foundation Trust provides some community health services to children and young people. The trust also provides mental health and learning disability services to both children and adults. Since the inspection, The Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust have entered into negotiations on working towards joining the two organisations together.*

*School nurse services are commissioned by Public Health, Cornwall Council and the Council of the Isles of Scilly and provided by Cornwall Partnership NHS Foundation Trust (CFT).*

*Contraception and sexual health services (CASH) are commissioned by Public Health, Cornwall Council and the Council of the Isles of Scilly and provided (in the main) by RCHT.*

*Child substance misuse services are commissioned by Public Health, Cornwall Council and the Council of the Isles of Scilly and provided by Addaction.*

*Adult substance misuse services are commissioned by Public Health, Cornwall Council and the Council of the Isles of Scilly and provided by Addaction.*

*Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are commissioned by NHS Kernow and provided by CFT.*

*A Sexual Assault Referral Centre (SARC) is commissioned by NHS England. The paediatric support to the SARC for under 18's is provided by RCHT.*

*The last inspection of health services for Cornwall's children took place in January 2011 (published in February 2011) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in the lines of enquiry for this review.*

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## The report

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

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## What people told us

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### **One foster parent told us:**

*Health visitors are fantastic. I've had the same one for 28 years now and what she doesn't know isn't worth finding out. I can ask her anything, she's always there."*

### **Another told us:**

*"All health workers are supportive. Because the children are looked-after they are generally prioritised for treatment. Even our GP sees the children on the same or next day because he knows how vulnerable they can be."*

### **When asked of their experiences of hospital emergency departments, one foster carer told us:**

*"We had to take one of the children to A&E with a fractured arm. They knew he was LAC but we still had to wait for three hours or more to be seen after triage. Even the paediatric waiting area was closed and didn't open until almost lunchtime. We had to wait in the general waiting area which wasn't very nice and this was only at the end of last year. There were then problems getting the right signature giving consent for the operation he needed to take place and this caused even more delays despite there being a full care order in place. I think it was poor communication between services (health and social care) that meant we had to wait for so long."*

### **When asked about health reviews and contact with the paediatrician one foster carer told us:**

*"She's absolutely fantastic. She relates to the children so well and knows them all by their Christian names. She talks to them and not at them and we all feel involved in the process. I can contact her just about any time. She's a friend."*

### **Another told us:**

*"Health assessments of old are nothing like they are now. Things are so much better than they used to be. I've been fostering for a long time and these last few years have made such a difference to the way things are run and the way we (foster carers) are looked after so that we can give better care to the children."*

### **When asked about what support foster carers in Cornwall receive, we were told:**

*"There is so much training on offer, so much to choose from. We get a book at the beginning of the year which tells us about all the courses on offer and lots of them are repeated at different times so you can nearly always get booked onto the course you want."*

**Another told us:**

*“The attachment training course was fantastic. My only suggestion would be that it is offered right at the beginning when you do the skills for foster caring training. It taught me so much about how to interact with the children and better understand them.”*

**We were told by foster carers that they are involved in the development of the child’s ‘life book’ to be given to the young person when they leave care:**

*“We keep photographs, certificates and other mementos of their (the children’s) time with us so when they leave care they have a history to take with them.*

**However, one recent care leaver we later spoke with told us:**

*“I didn’t get anything when I left care. I haven’t a clue about a ‘life book’ and I didn’t get a health passport either. I know how to book an appointment with my doctor if I need to but that’s about it. It would have been good to get a lot more information about health care.”*

**Two other care leavers we spoke with told us they too did not get any health information when leaving care. One told us:**

*“I have had to ask about everything. I know I can ask what to do but even some leaflets would have been good to keep.”*

**When asked what could be better when leaving care, all care leavers we spoke with told us that they would appreciate more health information. One recent care leaver told us:**

*“I wasn’t told what I had to do or not do when I left care about my health. In all honesty it’s a shame we don’t continue to get regular health assessments once we leave care. I liked to know how I was doing and I’d like to know how I’m doing now.”*

**We asked young people in care if they were prioritised for health care when, for example, they went to hospital. One young person told us:**

*“I had to go to A&E not long ago. There were queues of people waiting but I was called in before anyone else. I guess it was because I was in care but it didn’t feel right and I knew people were thinking why was I getting priority treatment. It would have been good if I had been asked first. I don’t like people to know I’m in care unless I want them to know. Just ask me first and I would have said “no thank you.””*

**And one young person told us:**

*“The health checks are good. A bit too good I think because they drag on a bit and get boring!”*

**Another young person told us:**

*“My nurse listens to what I’ve got to say. She sets goals for me to achieve and when I get it done she sets another one. I don’t think it’s just a day job to her. She really enjoys what she does.”*

**We spoke to one adult service user who received care and support from the ‘Breaking the Cycle’ team of substance misuse workers. She told us:**

*“I came here after my detox programme in late 2014, firstly referring myself to the adult substance misuse team and I was then referred to the Breaking the Cycle team. They have been working closely with me and my daughter and have been really helpful. I admit I’m here for my own benefit but the outcome is that my children benefit as well which is really good.”*

**She went on to tell us:**

*“My daughter starts a course next week with YZUP. Not because she drinks or anything but because I used to. It’s a way of supporting her.”*

**When asked if there was anything else she wanted to tell us about the services provided to her she told us:**

*“Nothing negative at all. Everyone has been great and although it’s ultimately up to me, I know I won’t start drinking again. I am getting all kinds of support which I know won’t go on forever but it’s reduced the risk lots. I’m feeling pretty good about myself right now.”*

**One 15 month old boy was brought into the paediatric ED following a fall from a staircase. His mother told us:**

*“The staff have been good with him, they were friendly with him and knew how to comfort him and get his confidence.”*

**A child on the paediatric ward told us;**

*“The nurses are kind, If I need to talk to them they let you. CAMHS understand you, they are calm and that really helps.”*

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## The child's journey

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

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### 1. Early help

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- 1.1 Most expectant women across Cornwall book their pregnancies early. There is an increasing trend for women to self-refer. The booking of pregnancy usually takes place before 12 weeks. The trust recognise that the current booking questionnaire does not sufficiently explore social vulnerability and incorporate learning from serious case reviews around details of partners and other children from previous relationships. The existing antenatal booking paper work in the hand held notes has been updated as a result.
- 1.2 Most women receiving ante natal care from midwives in Cornwall are seen alone early in pregnancy. This is good practice and gives expectant women an opportunity to disclose any domestic violence or to discuss any other confidential issue that they may not wish to discuss in the presence of their partner. We saw how women are routinely asked about domestic violence throughout their pregnancy. However, midwives are not always identifying opportunities for early support and intervention with vulnerable expectant women (**Recommendation 1.1**).
- 1.3 The role of the paediatric discharge liaison co-ordinator on the wards is highly valued. The post-holder was described as visible and providing a vital role in bringing together discharge arrangements and care packages for children with complex health care needs.
- 1.4 While we saw a few examples where health visitors and midwives are working closely and co-operatively to ensure effective case transfers and good early support to new mothers, this is based on long-standing relationships between individual practitioners rather than a systematic approach across the service interface. A robust ante-natal pathway for midwifery and health visitor liaison is not in place. As a result, there is inconsistent liaison and joint working between midwifery and health visiting to share information and prioritise families who would benefit from an enhanced health visiting package.

- 1.5 Whereas universal ante natal visits are routine health visitor practice and this is good practice, in some instances, health visitors have been unable to complete the universal visit as they have been unaware of the pregnancy until they receive the new birth notification. Recent changes to the process of notifications of pregnancy from midwives to health visitors implemented by the community trust is problematic, leading to a deterioration in relationships between some teams in parts of Cornwall. An unintended consequence of these changes is that some women are now experiencing delays in receiving their ante natal visit by the health visitor. For some women with additional vulnerability this is a lost opportunity to engage early with the family. This is not acceptable. Midwives are no longer required to communicate to health visitors when they discharge a new family from their care, unless there are ongoing problems. Again, this lack of contact between professionals does not promote a cohesive approach to joint working and has an impact on partnership working. The inability of the midwifery service to consistently and comprehensively handover cases to health visiting creates an inherent risk to safeguarding children and families as some vulnerable women and children are not being allocated health visitors at a sufficiently early stage. It is beholden on both provider trusts to ensure that there is a robust care pathway in place to ensure a seamless interface between the services and effective handover of cases in order that mothers and new-borns are consistently well served and receive appropriate support at the earliest opportunity (**Recommendation 1.2 and 3.19**).
- 1.6 We were also told that health visitors no longer provide supportive visits to those women who have had their babies taken into care at birth or who have had still births.
- 1.7 Some health visitor clinics are based at children's centres and this is effective in facilitating parents' access and engagement with wider community support services. This strong joint working between health visitors and children's' centres ensures all families have good access to a range of early help and support options.
- 1.8 Children and young people who attend the ED at Treliske Hospital book in with the reception team who obtain full demographic details. In most cases seen, however, the receptionists were not recording who accompanied the child or young person and who has parental responsibility. Some ED health practitioners recognised that this important information is missing and will record this as part of the screening assessment; however, this is not routinely captured. This is an important finding in many serious case reviews (**Recommendation 1.3**).

- 1.9 Similarly, ED staff are not routinely identifying children in households where adults present at the department with risk taking behaviours and following domestic violence. We saw very limited numbers of these adults being brought to the attention of the paediatric discharge liaison co-ordinator. The MIUs also do not demonstrate evidence of Think Family principles being included within the adult assessment proforma. No prompt questions are included in adult paperwork to ascertain whether there are children at home who may be at risk of hidden harm (**Recommendation 1.4 and 2.1**).
- 1.10 The paediatric ED is a secure, bright and cheerful area for children and young people to receive emergency care. Staff are able to observe children in the small waiting area and access is through a swipe card thus maintaining the safety of children in this area. However, the paediatric ED is a small five bedded cubicle area staffed with one paediatric trained nurse. This is insufficient and whilst we were there we observed one nurse trying to cope with a transfer from the paediatric ED to the paediatric ward, a direct admission from an ambulance crew of a poorly child with complex health problems and a teenager with potential head injury and vomiting (**Recommendation 1.5**).
- 1.11 There are protocols in place to ensure that children and young people are treated by the most appropriate trained health professional when they attend the ED. Current arrangements require any child under two to be seen by a doctor and any infant under 1 to be discussed with a senior ED doctor prior to discharge, there is no requirement for this to be with a paediatrician however. Children aged one year and under are not reviewed by a paediatrician or paediatric trained nurse prior to discharge from both MIUs inspected.
- 1.12 We saw good evidence of medical and nursing practitioners taking up opportunities to offer advice and support to young parents on routine healthcare and emergencies. In one case the doctor spent some time educating the parent on how to deal with a choking infant. ED health staff are good at communicating with children and young people. We observed good interaction, with nurses talking directly to their patient and obtaining consent where this was appropriate for their condition and age.
- 1.13 Children and young people leaving the ED without being seen are not followed up robustly. The GP discharge letter does make reference to the fact that a child had left the department without being seen, however, the ED does not have a formal policy to guide practitioners on what action to take (**Recommendation 1.6**).

- 1.14 We saw how ED are routinely identifying potential for early support and intervention by health visitors and school nurses within vulnerable families. However, in most cases we saw that although the paediatric discharge liaison co-ordinator was passing information appropriately to health visitors and school nurses, this was not being acted upon. This is a missed opportunity to safeguard children and young people at the earliest opportunity and is not acceptable (**Recommendation 3.17**). This area for development has also been drawn to the attention of Public Health England and Cornwall Council.
- 1.15 The use of a single IT system across all unplanned care settings is positive, ensuring practitioners can undertake a full risk assessment using information from any previous and multiple attendances. We saw a number of examples in both MIUs and Treliske hospital of good risk assessment and good identification of safeguarding concerns with prompt referrals being made.
- 1.16 We visited two minor injury units (MIUs); at Bodmin and a second MIU for Camborne and Redruth. At both MIU's, children and young people, especially those aged two years and under, are generally prioritised for treatment. Likewise, when it is recognised that a child is looked after by a local authority, they too will receive priority treatment, but this is according to individual nurse assessment and not PCH care policy. Children and young people can wait as long as adults according to the needs of other people attending the unit; all of whom are assessed according to a four tier system of need. The lowest tier being for those living with long term conditions or awaiting dressing changes and the highest priority tier being for patients with serious injury or potentially life threatening conditions.
- 1.17 In some MIUs, it is difficult for staff to maintain effective supervision of children and young people waiting for treatment due to the fabric of the building and this is recognised by PCH as an issue. Bodmin MIU does not have a separate treatment area specifically designed for CYP. Young people are seen in generic treatment areas separated by curtain screens to the front and walls to the sides to provide privacy. We did however observe health professionals providing care and support to young people in a discreet manner and where possible away from adults attending the unit. There is CCTV recording of the area but this is seen only by the hospital's main reception staff and not staff working on the MIU. Camborne and Redruth MIU reception staff maintain good sight of children and young people in the general waiting area from the reception desk. Camborne and Redruth MIU does have a specific treatment area for children and young people and where possible this is used at all times, although this is not guaranteed depending on the needs placed on the unit at any given time. The treatment area is specifically decorated with young children in mind (**Recommendation 2.2**).

- 1.18 We were advised at Bodmin MIU how holiday season attendees to the unit can have a marked effect on waiting times with some young people having to wait up to four hours to be seen. The target time for reception, assessment, treatment and discharge is currently set at four hours or less so having to wait four hours just to be seen significantly extends this target time. Camborne and Redruth MIU experiences the same influx as Bodmin. PCH told us that statistics show that the impact of visitor numbers are the same in both settings. We were advised that waiting times are regularly audited but staff members we spoke with in Bodmin were unaware of any actions being taken to negate extended holiday season waiting times.
- 1.19 Paperwork for children at MIUs is NICE compliant, with safeguarding trigger questions clearly visible. These were filled in consistently in all cases reviewed. Notifications regarding MIU attendees aged 18 and under are sent to the children's care management unit which then informs health visitors, school nurses and GPs of the attendance. All people attending the MIUs from out of area have their attendances notified to their own GPs by post. Where a person discloses that they do not have a GP, PCH's named nurse for safeguarding is informed who in turn notifies the named nurse in the patient's home area.
- 1.20 However, not all under 18 MIU attendances are reviewed in the MIU to ensure all vulnerabilities and safeguarding risks have been identified. Health professionals spoken with were not aware of any process of routine safeguarding lead or managerial oversight of attenders to the MIUs to ensure that all safeguarding issues have been identified and that operational safeguarding practice in the units is sound. We identified a case where safeguarding issues were clearly identified in the clinical record but the safeguarding questions were completed as no concerns. This discrepancy is likely to have been identified if the case was reviewed appropriately prior to discharge, ensuring the safeguarding of the child (**Recommendation 2.3**).
- 1.21 Referrals of individual cases between CAMHS and the child substance misuse services are made appropriately. Links between these services are underdeveloped however. Since the re-provision of the substance misuse service, there are no routine and regular meetings between these services and no joint appointments to see individual young people accessing both services. Regular inter-service engagement would facilitate information sharing and effective partnership working between the services to ensure young people experience effective "wrap-around" multi-disciplinary support which is likely to deliver improved outcomes (**Recommendation 3.1**). This area for development has been drawn to the attention of Public Health England and Cornwall Council.

- 1.22 We saw good family interventions from the Addaction Breaking the Cycle team leading to positive outcomes. While risk assessment is undertaken by Addaction as routine practice this is not always appropriately recorded to demonstrate that a full risk assessment has been undertaken and whether or not risk has been identified. Relationships with midwifery services are variable but generally good. Joint visits to meet with pregnant mothers are rare however, and there is no specific referral pathway from midwifery services into the substance misuse service (**Recommendation 1.7 and 4.1**). This area for development has been drawn to the attention of Public Health England and Cornwall Council.
- 1.23 Contraception and sexual health service provision across Cornwall is readily accessible by young people who do not have to travel far and who can be seen and offered treatment and advice confidentially. Cornwall children and young people are safeguarded well by CASH services. The screening assessment for all young people includes pro-forma questions to be asked by health practitioners at initial screening which encompasses child sexual exploitation (CSE) and risky behaviours that might put them at risk of harm. Consultation and informal discussions with safeguarding leads and children's social care are common place and will result in a referral to the MARU when considered appropriate. CASH practitioners cited good working relationships with multi-agency partners across Cornwall, including Brook services and school nurses.
- 1.24 Regular consultation with young people about how CASH services are provided, has resulted in extended centre opening times and young people's views and opinions have shaped the way services are provided to them in Cornwall. CASH clients also assisted in the production of 'Cornwall specific' sexual health promotion posters.
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## 2. Children in need

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- 2.1 Expectant women with additional social vulnerability are supported by RCHT community midwives. There are no specialist midwives in perinatal mental health, teenage pregnancy, learning disability or substance misuse. A special parenting service is available to parents with identified learning disability to provide early assessment and support. This means that expectant parents or new parents with learning disability can be supported through comprehensive and appropriate packages of care to safeguard the infant.
- 2.2 The strategic specialist midwife in RCHT is developing and reviewing care pathways and is arranging training for community midwives to ensure that they are appropriately skilled to deliver services to these vulnerable women. There are no joint ante natal appointments or clinics with other services that may be involved with these expectant women.

2.3 There is no forum for multi-agency discussion on women with additional social vulnerability to co-ordinate a package of multi-agency support. This is a missed opportunity to identify and plan the support of these new families early (**Recommendation 1.8**).

2.4 Health visitors follow up maternal mood assessment well; routinely assessing this at ante natal, new birth and 3-4 month visits ensuring that mother's with declining mental health and those who would benefit from additional support are being identified beyond the new birth visit. Women with identified mental health needs in pregnancy benefit from specialist support from the consultant led peri-natal mental health team. We saw evidence of how the specialist team work with the woman, her family and the midwife to develop a birth plan to support the woman and inform midwives of her individual needs. This is good practice. However, the birth plans would benefit from a more SMART and individualised approach to help midwives identify individual relapse indicators and what action to take.

**Case example:** *A woman booked her pregnancy with the midwifery team early and disclosed a significant history of depression. She was offered a referral to the peri-natal mental health team and she agreed to their involvement.*

*She continued to see her community midwife at regular intervals throughout the pregnancy alongside practitioners from the peri-natal mental health team. The peri-natal team provided her GP and midwife with a comprehensive update on their involvement and plans for the birth and post natal period.*

*The peri-natal team were responsive to the changing mental health of the woman and through a partnership approach with community midwifery she was able to deliver her baby at home which had always been her preference. The peri-natal mental health team visited her in the post natal period to ensure she was coping and that her mental health was stable.*

2.5 We heard how the relationship between midwifery and Addaction's adult addiction service is improving. Joint visits to meet with pregnant mothers are rare although contact is made between both agencies when required. There is no specific referral pathway from midwifery services into substance misuse services and this is an area for development as women in different areas may experience differences in accessing the substance misuse support service as a consequence (**Recommendation 1.7 and 4.1**).

- 2.6 Health visitors are well engaged with the common assessment framework (CAF) and prioritise attendance at team around the child (TAC) and child in need (CIN) meetings. However, health visitor care plans are significantly underdeveloped. Most examples we reviewed were basic in nature and generic, lacking clear outcome driven goals. Analysis and evaluation of plans was poor and it was difficult to measure the impact and success of interventions (**Recommendation 3.18**).
- 2.7 The implementation of link safeguarding meetings between health visitors, school nurses, other services such as Addaction and GP's across the county is variable; however where these meetings exist, we saw evidence of consistent health visitor and school nurse attendance and this is facilitating effective information sharing and support to vulnerable families in those areas.
- 2.8 The family nurse partnership (FNP) programme is well established in Cornwall, and cases highlighted positive outcomes for young people involved with the service. This included one young mum and her baby who, following sustained engagement with FNP is no longer subject to a child protection plan. Young parents can either be referred to the FNP or if the service is unable to take the referral, then this is passed to health visiting and the local authority's Careers South West who offer a good range of support.
- 2.9 Despite the expectation by managers that health visitors will hold face to face handovers with school nurses of children with identified vulnerability, we did not see evidence of this taking place. This impedes information exchange on important safeguarding issues and there is a lack of assurance that children and young people are adequately supported and kept safe at this key transition point (**Recommendation 3.2**).
- 2.10 School nurses told us that notifications for some multi-agency meetings can be received late and in some cases, after the meeting has taken place, however we saw limited responsibility taken by school nurses to ensure they were aware of meeting dates in advance or seeking outcomes of meetings they could not attend. School nurses are not fully engaged in decision making processes where children are stepped up or down from CIN and child protection plans (**Recommendation 3.3**).
- 2.11 We met some very dedicated and committed school nurses this week, however, capacity issues are significantly affecting the school nurse teams' ability to provide a highly visible presence and ongoing early intervention work in schools. The service finds it difficult to demonstrate good outcomes and strong evidence of impact of school nurses' involvement in cases.

- 2.12 CAMHS work closely with RCHT emergency department (ED) and paediatric wards, offering advice and support through daily telephone contact with the ED and regular meetings with ED managers. Young people who attend the ED following an incident of self-harm or who are in mental health crises are supported well. Young people in crisis are admitted to the paediatric ward in line with NICE guidance to “cool off”, pending CAMHS assessment or awaiting appropriate in-patient bed identification. We saw evidence that individual risk management plans are developed with the ward to support paediatric staff in providing care to the young person. We saw a case example demonstrating diligent work over the weekend by a CAMHS practitioner attending the paediatric ward a number of times following a young person’s admission and working very effectively with hospital clinicians to ensure the young person was well supported. We have also seen good, well managed support being offered to young people in mental health crisis and their parents to sustain and support them in their own home in managed risk situations subject to close governance. Where young people requiring in-patient tier 4 treatment are placed at distance from Cornwall, the CAMHS service is creative in how they maintain contact and support the young person.
- 2.13 Young people attending the ED following substance or alcohol misuse do not routinely benefit from targeted support as part of an agreed care pathway between ED and the local Addaction, YZUP. We saw how some young people are kept in the ED until they are medically fit for discharge and then allowed home with an appropriate adult without any referral or communication with YZUP (**Recommendation 1.9 and 4.2**). This area for development has been drawn to the attention of Public Health and Cornwall Council.
- 2.14 At Addaction, the adult substance misuse service, we examined records of adult substance misusers and reviewed risk assessments for those adults. risk assessments did not always articulate that risks to children and young people in families had been considered, even in the negative if no risk had been identified (**Recommendation 4.3**). This area for development has been drawn to the attention of Public Health and Cornwall Council.
- 2.15 Where there are children living in the households of adults who abuse substances or alcohol their details are routinely recorded and identified whether the child was subject to child protection plans or otherwise. This included siblings. However, these important details were not always recorded in the same place within different records, some being recorded in client contact notes where this key information may become “lost” in the body of the record.

**Case example:** *Adult engaged with Addaction substance misuse service.*

*There were three children in the family and we were told by the key worker that risk to the children had been considered and that there was no current risk.*

*However, there was no documentation on the case record to evidence that risk had been considered, what the risk assessment process had been, or what the decision making process had been.*

*It is essential that evidence of comprehensive assessment of risks to children is clearly recorded on the case record in order that any practitioner or manager accessing the record can easily assure themselves that this has been undertaken.*

- 2.16 The breaking the cycle team (BTC) within Addaction's adult substance misuse services work with problematic substance misusers and their families, recognising the role and needs of families in treatment for substance misuse. The team focuses not only on adult client interventions but also the children and young people of those substance misusers. Addaction workers provide an individually designed care package, which takes into account the needs of the whole family. Various interventions are offered, including an eight week family day programme to explore family relationships, understand your child groups, MPACT (moving parents and children together) designed to support the family as a whole and sail-a-day outdoor sport activity of sailing therapy.

**Case example:** *Parents both engaged with Addaction for alcohol misuse who had two children.*

*Both parents were engaging in 'binge drinking' and one child was involved in anti-social behaviour with the other no longer in formal education. Domestic violence was prevalent in the family which the children would witness. Both children were made subject to child protection plans being considered at risk of emotional abuse and neglect.*

*The mother was supported by Addaction recovery workers working closely with a Breaking the Cycle (BTC) family worker to address her issues around alcohol. Mum took part in one-to-one appointments with her recovery worker and home visits by the BTC worker. Because of this support she was able to address her alcohol problems and better understand the impact her and her then partner's alcohol addiction was having on the children. She separated from her partner soon after.*

*Support was provided to one child in relation to self-esteem and confidence allowing the child to explore their educational needs for the future. Different forms of education provision were explored.*

**Outcomes:** *Mum and the children are doing well. Both children are now in full time education again and the second child is no longer involved in anti-social behaviour and does not now require additional support.*

*The family are now closed to the BTC team and the children are no longer subject to child protection plans*

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### 3. Child protection

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- 3.1 Midwives can refer an expectant mother to children's social care at any time during the pregnancy. However, we saw examples of initial child protection conferences taking place late in pregnancy despite early referral. There is no joint protocol between midwifery services and the local authority on pre-birth and discharge planning to help guide both agencies on what the minimum standards and expectations are when planning the protection of these vulnerable unborn children (**Recommendation 1.10**). This area for development has been drawn to the attention of Cornwall Council.

**Case example:** *A 30 year old woman self-referred to midwifery services. At booking the midwife noted that the woman had a significant mental health history and that her previous children had been placed into the care of the local authority and subsequently adopted.*

*The midwife made a referral to the MARU. However, although there was a note on the record to say that the referral was made there is no copy of the referral held on file.*

*The patient record shows good liaison between the midwife and the social worker. However, although the referral to children's social care was made early in pregnancy, the initial child protection conference (ICPC) did not take place until the woman was 34 weeks pregnant.*

*The midwife attended the ICPC and attended core groups and was involved in creating a child protection plan to safeguard the unborn child at birth. The plan included sending out national alerts to maternity units as there was a risk that the woman might abscond from Cornwall*

*The midwife carried out weekly home visits towards the end of the pregnancy as there was an identified risk that the woman might not present at the hospital in labour and try to conceal the birth.*

*The baby was removed at birth and placed into a secure foster placement and was therefore protected.*

*The midwives advised health visitors of the birth.*

*This case demonstrated good efforts by the midwife to keep engaged with the woman especially in the latter part of her pregnancy when risk of absconding had been identified. The late ICPC did not facilitate a joint approach to supporting a vulnerable family across partner agencies; especially as women with complex social vulnerability are more likely to deliver their babies early. There was no evidence of health visitor input into this vulnerable family prior to birth and no follow-up supportive visit to the mother whose baby had been taken into care.*

- 3.2 Practitioners across services, including the MIUs and primary care are regularly and increasingly contacting the multi-agency referral unit (MARU) to discuss concerns and seek guidance prior to making MARU referrals and this is positive; facilitating appropriate referrals being made. However, in most services, no record is kept of these conversations in the patient notes and there is an over reliance by practitioners on the detail of their concern having been covered in the conversation rather than setting this out clearly in the written referral. While we did see examples of good quality referrals from individual practitioners within some services, generally the quality of MARU referrals is underdeveloped across the health economy. Risks of harm and the practitioner's level of concern is not always clearly articulated and the expected response from the MARU not always set out. Referrals from some services contained overly clinical medical language which is not supportive of effective risk assessment by a non-clinical decision maker at the MARU (**Recommendations 1.11, 2.4 and 3.4**).
- 3.3 Practitioners in some health services told us that they do not routinely get informed of MARU decisions made about any action to be taken by children's social care as a result of referrals.
- 3.4 CASH services have a representative at the MARU and as such practitioners are routinely updated as to local and national safeguarding issues and the progress of referrals made on a monthly basis.
- 3.5 Addaction YZUP practitioners make regular referrals to the MARU but these are always done by telephone consultation and are not followed up as written referrals. Whilst notes of the telephone call made are on client notes, the reasons for making the referral are not comprehensive and do not clearly articulate detailed reasons for the referral being made. (**Recommendation 4.4**). This area for development has been drawn to the attention of Public Health and Cornwall Council.

**Case example:** *A 16 year old male attended an MIU in the company of an older male who introduced him to reception staff, assisted in the registration process and then left the unit agreeing to collect the young person when he had received treatment for an injury to his hand.*

*During assessment of the injury and in discussion with the nurse, the young person disclosed that he had 'run away' from home some time ago and was living and working without any legal guardian. He further disclosed that he had been abused as a child and was known to children's social care due to his family situation. The older male he had attended the unit with was providing accommodation and paid employment to him.*

*The nurse attending to the young person clearly considered the potential for child sexual exploitation (CSE), developed a good discussion about his background and asked appropriate questions to explore this possibility. The young person was given ample opportunity to disclose to the nurse but did not do so. The nurse did however consider the lack of legal guardianship a concern and, in agreement with the young person, made a referral to children's social care.*

*We saw good quality recording of the nurse's concerns in the patient records, a chronology of events that led to the young person attending the MIU and a plan of action following discharge from the unit, including making personal contact with the young person's GP. The referral was good quality, clearly recording discussions that had taken place and the concerns of the nurse involved. A discussion also took place with the employee of the young person who agreed to the referral being made.*

*The subsequent assessment did not identify any safeguarding issues for the young person.*

- 3.6 With some exceptions, MARU referrals are not routinely uploaded onto case records in provider organisations resulting in an incomplete audit trail. Without a copy of the referral retained by the referring agency, use of the multi-agency escalation policy in cases where there may be professional differences regarding any further action, is undermined. This practice also does not facilitate the provision of effective quality assurance by operational managers to promote continuous improvement (**Recommendations to providers as set out in paragraphs 5.2.8 and 5.2.9**).
- 3.7 In adult mental health, there is a prompt in the risk summary documentation to identify children with whom the adult has contact and this is positive; in line with Think Family principles. However, there is no standard adult mental health assessment template and individual practitioners have different approaches. Ensuring that child safeguarding issues are considered as part of the assessment is therefore reliant on the knowledge and awareness of individual practitioners rather than consistent good practice supported and guided by an assessment template and framework (**Recommendation 3.6**).

- 3.8 There is a clear expectation from the safeguarding lead and managers within the adult mental health and CAMHS services that practitioners will be members of the Team Around the Child (TAC), core groups and attend child protection conferences. To ensure that invitations from children's social care to mental health practitioners are directed effectively, a pathway has been established whereby all invitations are sent to the mental health care management centre. This has improved the targeting of invitations to the appropriate worker overall and is a very positive joint development.
- 3.9 In common with other health practitioners, midwives are expected to prioritise attendance at all child protection and child in need conferences. However, again in common with other providers, there are no routine recording and reporting arrangements in place to provide the Trust's board assurances that staff attend conferences. We saw evidence of midwives not attending some child protection meetings and because of weak governance arrangements on record keeping, we were not assured that reports had been sent to conference as the patient record was incomplete (**Recommendation 1.13**).
- 3.10 There is no non-attendance (DNA) policy in the adult mental health service to guide practitioners where an adult's non-attendance at an appointment may be an early indicator of withdrawal from service and therefore indicative of increased risk to children subject to child protection or CIN plans. While cases do need to be considered and risk assessed individually, best practice is for a comprehensive DNA policy and guidance to be in place to support effective risk assessment and decision making by practitioners in order to protect vulnerable children (**Recommendation 3.7**).
- 3.11 In the CASH service, the approach to young people who do not attend for pre-booked appointments is robust. Missed appointments are followed up by practitioners as per the RCHT policy. Discussions can take place with the Trusts named nurse for safeguarding to share relevant safeguarding information and when considered necessary a referral to children's social care via the MARU will be made.
- 3.12 Addaction key workers attend child protection meetings routinely giving verbal reports rather than submitting written reports in advance of case conferences in line with the multi-agency template. As a result, it is not always clear that issues have been shared with the parents ahead of the conference and the client record lacks detail on the issues or progress being reported. This area for development has also been drawn to the attention of Public Health and Cornwall Council.

- 3.13 There is more to do to support less experienced staff in their ability to raise professional dissent within child protection conferences and to discuss and escalate concerns through supervision and line management. A multi-agency escalation policy is in place, but health visitors told us that this is used inconsistently and some practitioners lack confidence in knowing when to raise a professional challenge. We understand that to date the effectiveness of the escalation policy and how practitioners raise professional dissent issues has not been audited or evaluated by the Cornwall and Isles of Scilly safeguarding children's board (CLOSSCB).
- 3.14 We saw inconsistent approaches by practitioners across services in CFT to uploading documents such as child protection, CIN and TAC plans onto case records. While we did see a case example where the child protection plan had been uploaded onto the child's case record in CAMHS, CFT policy is for practitioners to extract their role from the child protection plan and include this in the case record. This is poor practice. It creates a risk that practitioners and managers will not understand and maintain an awareness of the whole plan and the roles and responsibilities of other services in safeguarding the child. It does also not promote effective multi-disciplinary child protection work (**Recommendation 3.8**).
- 3.15 We did not see evidence of routine direct communication between health practitioners from different services working with families where children are known to be at risk or subject to child protection plans. Practitioners across services demonstrated a reluctance to talk directly to other health professionals about cases held in common. Reliance on professionals exchanging information at formal child protection meetings and core groups alone is not sufficient to ensure effective multi-agency working to protect children and young people. We did see examples in adult mental health of good direct liaison with police and children's social care. However, where adult mental health and adult substance misuse are involved in cases where child protection and other safeguarding measures are in place, direct liaison between them, health visitor and school nurse practitioners working with the child is not routine. This is of concern as lack of inter-service communication and information sharing is a feature of serious case reviews. We found a level of assumption in school nursing that other teams were seeing young people known to be at risk in cases open to the service but with no active school nurse practitioner engagement (**Recommendations 1.14, 3.9 and 4.6**). This area for development has been drawn to the attention of Public Health and Cornwall Council.
- 3.16 Use of contingency plans in adult mental health is recognised good practice and a requirement of the service and operational managers monitor practitioners' compliance with this expectation closely. Contingency plans prioritise child care arrangements in the event of a mental health relapse or crisis. This is positive and prompts the practitioner to prioritise the needs of the child if the parent is unable to provide appropriate care. However, case examples we saw did not consider parenting capacity or child care as part of the indicators of relapse (**Recommendation 3.10**).

- 3.17 Adult services for mental health and substance misuse do not routinely share relapse indicators and contingency plans with health visitors and other professionals. We saw no case examples in adult services where this had been done and were told that this does not happen routinely. Other services, such as health visitors or social workers may be visiting the family home regularly and if properly informed, may be best placed to pick up signs of relapse at an early stage. The early identification of deteriorating parental mental health or substance misuse relapse can prompt early and effective intervention and prevent an increase of risk to children in the family. It is important, therefore, that specialist health services share expertise and specific risk indicators and relapse plans to ensure all agencies working with a family can respond promptly when necessary (**Recommendation 3.11 and 4.7**). This area for development has also been drawn to the attention of Public Health and Cornwall Council.
- 3.18 Health services in Cornwall are well engaged with the multi-agency risk assessment conference (MARAC) arrangements which identify support for victims of serious domestic abuse incidents and notification and information sharing of domestic violence incidents is well developed. In health visiting, there is good awareness and joined up working with domestic violence workers facilitating health visitors risk assessment and work with families where domestic violence is an issue. The establishment of domestic violence champions underway within the health visitor teams will further strengthen this aspect of work.
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#### 4. Looked after children

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- 4.1 Looked after children are well served by the children in care (CIC) health team and young people taken into care can expect to have their health needs assessed in a timely fashion. The designated doctor for looked-after children undertakes all initial health assessments (IHA's) and also then acts as community paediatrician for the child if required. This ensures a high quality service with good continuity of health professional for children and their carers.

- 4.2 Increases in the capacity in the CIC health team has also had a positive impact on the timeliness of review health assessments (RHAs) and enabled RHAs to be completed exclusively by specialist CIC nurses rather than by universal services as was the previous arrangement. Children and young people are now being given choices on where and when their RHA takes place and this is an improvement achieved through the service remodelling. Timescales for RHAs have been adjusted in advance of statutory timescales to ensure they are in line with the child's statutory CIC review. This is very positive, ensuring that the most up to date information on how the child's health needs are being met is available to the review and to prevent drift in health actions taking place. CIC nurses maintain close links with foster carers and residential homes undertaking quarterly contact calls to check on ongoing health issues.
- 4.3 Arrangements for the quality assurance of RHAs by the designated nurse are effective. IHA's and RHA's seen were comprehensively completed and outcome focused, and the voice, personality and individuality of the child was strongly demonstrated. Although the resultant health plans were not always fully SMART, robust arrangements are in place to ensure health plan actions are reviewed every three months to ensure that follow up has taken place.
- 4.4 GPs and CAMHS, where this service is working with the child, are not routinely contacted for IHAs and RHA information and therefore there is the potential for the health assessment to not be fully informed and for health reviews not to fully reflect the child's emotional journey (**Recommendations 1.15 and 3.12**).
- 4.5 Strengths and difficulties questionnaires are not being used to best effect to inform the health reviews and opportunities to engage the young people themselves in evaluating their emotional growth over the time they are in care are being missed (**Recommendation 1.16**).
- 4.6 The CIC health team actively support young people to access health appointments, recognising the high risk that many young people are reluctant to engage with generic services. This is effective in ensuring that young people who are looked-after have their health needs met.
- 4.7 Whilst young people clearly benefit significantly from support from the CIC team, the absence of effective caseload transfer arrangements back to community health when a child is no longer in care means that a child or young person may not have their health needs met when they are de-accommodated. This lack of continuity is detrimental to cohesive health planning and there is a lack of assurance that these vulnerable children's health needs are being met on an ongoing basis (**Recommendation 1.17**).

- 4.8 The care leaver health offer is good. Care leavers are being provided with good quality and sensitively written age appropriate summary health information as they leave care. Care leavers are provided with health care summaries in the form of passports at age 15, updated at appointments between 15 and 18. This encourages young people entering adulthood to engage with managing their own health and wellbeing through a phased process of independence. In the course of this national review programme, we have seen a number of areas developing their care leaver offer based on the Cornwall model.

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## Management

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

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### 5.1 Leadership and management

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- 5.1.1 Cornwall is making progress on addressing the issues of child sexual exploitation with the provision of appropriate multi-agency arrangements and all key agencies are represented. The new chair of the safeguarding board (CLOSSCB) is working to expand the focus of the CLOSSCB beyond child protection to encompass the wider child safeguarding agenda.
- 5.1.2 There has been no cohesive approach to safeguarding across Cornwall for primary care and the named GP role has been unable to provide sufficient leadership and support due to lack of capacity. GPs have good links with the designated doctor and report he is easily accessible for advice and guidance and GPs are making increasing contact with MARU for advice or in advance of making referrals. We met a number of GPs who are prioritising attendance at CIN and child protection case conferences and who are members of core groups and can demonstrate good proactive safeguarding practice and engagement with arrangements but overall, this area remains in need of development. GPs report good relationships with adult mental health, meeting adult mental health practitioners monthly to discuss cases; some GPs tell us that communication with CAMHS is more problematic. The provision of a Cornwall and the Isles of Scilly primary care safeguarding children and adults lead funded through NHS England for a term of 12 months, is a positive development. The post has yet to be appointed.

- 5.1.3 There is good leadership from the designated nurse and doctor for safeguarding and practitioners value the advice and guidance they have from named professionals in their service. However, overall, the capacity of named professionals across provider services is very limited and this is a factor in the underdevelopment and lack of robust operational governance arrangements across the community.
- 5.1.4 The recently appointed specialist midwife for women with complex needs is providing good leadership and making good progress in developing care pathways for expectant women with mental health needs, who may experience domestic violence or who have a learning disability. These pathways will be launched once midwives have received appropriate training. She is currently reviewing the drugs and alcohol guidelines and is updating the safeguarding pathway.
- 5.1.5 The current arrangements for the named safeguarding children professionals within the RCHT are not sufficiently resourced or compliant with Working Together 2013 and the Intercollegiate Guidance. The named nurse is supported in her role by a team of link safeguarding nurses who are employed throughout all directorates across the organisation. These link nurses have no additional resource allocated to this role and the current arrangements for the link safeguarding nurses are not robust. Performance in the role is not evaluated as part of the post-holder's personal development review and there is no formal role description. Current arrangements do not require all safeguarding links to attend regular meetings. There is a lack of robust performance data collection and reporting and an underdeveloped audit programme to ensure compliance with policy (**Recommendation 1.18**).
- 5.1.6 The safeguarding lead for anaesthetics within RCHT is the Lead Paediatric Anaesthetist as recommended by The Royal College of Anaesthetists and The Association of Paediatric Anaesthetists of Great Britain and Ireland. The role of named midwife is embedded within the job description of the clinical matron for community midwifery and foetal medicine and does not reflect the job as outlined in the intercollegiate guidance. There has been a recent appointment to the post of specialist midwife for women with complex needs who is taking the strategic lead for developing maternity services to meet the needs of these vulnerable women. (**Reference recommendation 1.18**).
- 5.1.7 There is limited capacity for the named nurse in Peninsula Community Health to drive forward an agenda of continuous improvement in safeguarding practice within the MIUs as the post holder is also lead nurse consultant for the 12 MIUs across the county. This does not facilitate the provision of an effective children's safeguarding quality assurance framework overseen by the named nurse (**Recommendation 2.5**).

- 5.1.8 There is currently no operational oversight or comprehensive review of all ED and MIU attendances of children, young people and adults, including adults with concerning behaviours to ensure that all opportunities to support vulnerable families are identified and responded to prior to or soon after discharge. As a result, the PCH and RCHT boards cannot be assured of good and effective safeguarding practice within their acute services. The providers are predominately providers of health services to adults. However, particularly in the MIUs, there are significant numbers of children and young people accessing emergency treatment from PCH. Currently, services to children and child safeguarding do not have a high profile in the organisation; it does not feature on the PCH website and there is not explicit and demonstrable progress towards ensuring a Think Family model of care is established (**Recommendation 2.6**).
- 5.1.9 We saw a number of cases which highlighted a gap in early years monitoring and support for the 2½ -5 year old group and there is scope for partners to explore ways to address this gap to which, in part, national policy is contributing. Most children in this age bracket have no contact with the health visiting service until they are seen in school by a school nurse. School nurses told us that they are identifying high numbers of children starting school with toilet training and bottle feeding issues. In one case, developmental delay in a child aged three years whose family had moved into Cornwall from another area was identified by a diligent youth offending service (YOS) specialist nurse working with an older sibling and the child was engaged promptly with appropriate support.
- 5.1.10 The looked-after children's health service is well led by the designated doctor and designated nurse and governance arrangements are sound. Young people are actively involved in the development of the looked-after children's health service and service user involvement, such as the production of You Tube videos on how to register with a GP and other issues, is a strength.
- 5.1.11 Good practice seen in school nursing is based on strong individual practitioners rather than being underpinned by organisational processes to support co-ordinated and outcome driven working. The service has explored innovative ways of working to ensure it meets the national child measurement programme targets, including the introduction of band 2 posts offered as NVQ apprenticeship schemes to undertake the weight and measurements of 10000 children across Cornwall, thus releasing school nurses to undertake their other clinical duties. An LSCB agreed process is in place intended to govern school nurse attendance at ICPC and child protection conferences; developed to reduce the burden on school nurses and reflect the capacity issues, however this process is not consistently complied with and operational monitoring is weak. This area for development has been drawn to the attention of Public Health England and Cornwall Council.

- 5.1.12 CAMHS is working on strengthening its approach to core assessment, care planning and outcome measurement both in terms of development of electronic templates and introducing a more systematic approach to record keeping to promote an increased focus on measurable outcomes. Guidance on good care planning practice has been issued to staff. We saw examples of case recording which was reflective of this more systematic and more clearly structured approach to practice and service intervention, but there was some inconsistency in how practitioners record the care planning and intervention and not all care plans are SMART.
- 5.1.13 The current client record system in CFT's adult mental health service is not being used to best effect to drive best practice in relation to child safeguarding: there is no flagging system in place to alert practitioners and managers that a vulnerable child or children is present in the case. As a result, adult mental health team managers are unable to easily identify which cases on individual practitioners' or team caseloads include children subject to child protection or CIN plans or children with other identified vulnerabilities. The lack of identification of the cohort of child protection/CIN cases in adult mental health teams and the service as a whole also means that the Trust training needs analysis is unlikely to be comprehensive (**Recommendation 3.13**).
- 5.1.14 In adult mental health and adult substance misuse, details of children within the family are included with free text assessments or progress notes rather than in the client's demographic or personal details. There is, therefore, a likelihood that this information becomes "buried" in the record over time and the cases we reviewed demonstrated this. As a result, managers and practitioners in adult mental health and adult substance misuse do not necessarily have a full understanding of the issues within a case on accessing the case record and this exacerbates risk that hidden harm issues may not be identified and considered by the practitioner in their everyday work with their client and subject to effective managerial oversight (**Recommendation 3.14 and 4.5**).
- 5.1.15 While the adult mental health service is working towards a Think Family model, this is at a very early stage of development; there has been no training on the model and there is not currently a strategic plan to ensure the model becomes embedded across the service. Managers told us that practitioners are more aware of the need to prioritise the safeguarding of children while working primarily with the adult in a family or household. Systems, processes, training and supervision arrangements are not in place, however, to ensure this is routine practice and subject to effective governance arrangements within CFT (**Recommendation 3.14**).
- 5.1.16 From case recording in the adult mental health service, it is not always clear from the terminology used in the client record and from our discussions with staff, that practitioners have a clear understanding about the status of a child and child protection processes (**Recommendation 3.14**).

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## 5.2 Governance

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- 5.2.1 The Cornwall and Isles of Scilly Safeguarding Children Board (CLOSSCB) is the statutory body responsible for protecting children and young people from significant harm and for promoting their welfare. All local health organisations are full members of the Board, along with representatives of all the other agencies which provide services to children and families. The designated professionals for safeguarding children chair the local safeguarding children health forum; this links to the CLOSSCB practice subgroup. The health forum has representation from health providers from the NHS and private sector within the county. Action plans from serious case reviews (SCR) or serious incidents (SI) are monitored by the individual providers, safeguarding children health forum, and the learning group of CLOSSCB.
- 5.2.2 There is a lack of strong and effective governance from commissioners and providers in ensuring that services across Cornwall deliver in a consistent, joined up way resulting in good outcomes. This is a significant and strongly evidenced area for development and is resulting in some children being at risk. The chair of the CLOSSCB, health commissioners and strategic managers across provider services recognise this as a priority development area (**Recommendation 5.1**).
- 5.2.3 Recognising that midwives are not always identifying opportunities for early support and intervention with vulnerable expectant women, health commissioners have directed that by summer of 2015 all women booking their pregnancy should benefit from a pre-CAF screening. This will strengthen the opportunity to identify vulnerability or additional needs early.
- 5.2.4 CAMHS and adult mental health practitioners, midwives, the YOS specialist nurse practitioner, school nurses and health visitors do not always record all their activity on the case record and we saw some very poor case recording with limited emphasis on analysis in some services. This is further evidenced below and is addressed through the recommendations at the end of this report.
- 5.2.5 In health visiting, not all practitioners were compliant with the record, observation, assessment and plan (ROAP) recording system adopted by the service.
- 5.2.6 In school nursing there was significant inconsistency and omissions in record keeping and documentation. Safeguarding information referred to within the main body of the notes as being held on the case record, was not always uploaded.

- 5.2.7 At Addaction, client notes reviewed clearly articulated a person centred approach by practitioners. Where there were children in the family, they were regularly considered and mentioned in case records, including the child's interactions with key workers and other adults, including parents. In all cases seen however, where child protection measures were in place for the children and young people of adult substance misusers, the minutes following child protection conferences and other meetings were not being routinely uploaded to the HALO client record system. We were advised by key workers that they were aware that this should now be the case but as the system was relatively new at the time of this review, there had been delays in ensuring this is done. This means that electronic records are not currently a full record of client interactions and multi-agency risk assessment and child protection decisions.
- 5.2.8 Across all health services we visited, we saw examples of records lacking sufficient detail about practitioners' actions and the content of sessions with the young person or adult. Safeguarding and child protection records held within health services, including Addaction, were incomplete. Copies of referrals to children's social care are not routinely kept, reports for child protection conferences are not held as part of the record, neither are the formal minutes from child protection conferences. Where these key documents were kept on record, there was variation in where they were located. There was an over-reliance on other agencies holding information. This is not good practice. Chronologies are not routinely used and this makes it difficult for a practitioner to keep an effective overview of the case. Lack of chronologies in provider services is a frequent finding in serious case reviews
- 5.2.9 In services where case records are not accurately including all practitioner activity, this is not ensuring an accurate evidence and audit trail to support professional and service accountability. It does not facilitate managers' ability to quality assure practice as demonstrated through the case record or effective case transfer to other practitioners or services. In all services, we did not see evidence of routine monitoring of case records by operational managers and overall, case record management is weak. Although we are told that managers do undertake periodic case recording audits in some services, it is difficult to see the impact of this in ensuring consistent good recording practice. (**Recommendations 1.12, 3.5 and 4.5**). This area for development has been drawn to the attention of Public Health England and Cornwall Council.
- 5.2.10 Recording practice at the MIUs operated by PCH was good. Records reviewed were written clearly, gave good detail of examinations and treatments with good use of diagrams to indicate locations of injuries sustained by children.
- 5.2.11 Where school nurses are producing reports for child protection case conferences, there is good operational oversight to ensure the quality of information contained in reports is of a high standard.

- 5.2.12 There was no available signage in either MIU waiting areas we visited to inform parents and carers of children and young people that referrals might be made to children's social care should health staff consider it necessary. Parents and carers may not therefore, be pre-informed of what might happen should staff suspect neglect or other safeguarding concerns. We were assured however, that should a referral be considered necessary then the parents or carers will be notified of the decision.
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## 5.3 Training and supervision

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- 5.3.1 As reported above (5.2.2), there is a lack of leadership by the health providers in ensuring that providers across Cornwall deliver services in a consistent and joined up way derived from a commonality of understanding and sharing of lessons learnt. An example in relation to training in the absence of a commonality of understanding being; health visitors have received training in supporting new mothers who have mild to moderate mental health needs. Midwives are due to receive training in the very near future. However, there is no joined up approach to ensure that the key messages delivered as part of the training are consistent across agencies.
- 5.3.2 Peninsula Community Health told us that all MIU practitioners undertake specific degree level education relating to paediatrics including recognition of the sick child. The sessions form part of the Enhanced Practice in Minor Injuries module (NURC 316) validated by Plymouth University. In addition the Resuscitation Council Paediatric Immediate Life Support course is mandatory for all MIU Practitioners. Each unit also has a lead for paediatrics who meet their peers regularly to gain and disseminate new knowledge. Given the high numbers of children accessing MIUs, this and regular access to refresher training to ensure practice is current, is essential.
- 5.3.3 Practitioners across health providers told us that the level 3 training delivered by Reconstruct, an independent provider, is valued, particularly in respect of raising staff awareness of roles in social care and the support that is available locally from a multi-agency perspective.
- 5.3.4 Practitioners at the MIUs are appropriately trained to level 3 and have made good use of the Reconstruct training in their risk assessment practice. Nurse practitioners at both MIUs attend a full day's multi-disciplinary safeguarding level three training undertaken by Reconstruct and accredited by the LSCB. The day's programme includes recognising and understanding the signs and impact of abuse, working in partnership and group case analysis, evaluation and action planning. CSE is included as part of the days training. We spoke with an MIU nurse practitioner who told us that she had recently undertaken the training with teachers, social workers and GPs. As a result of the training, the practitioner told us she felt confident in being able to recognise and report child safeguarding concerns.

- 5.3.5 We heard how a senior adult medical consultant had attended safeguarding children training and had subsequently contacted the named doctor to discuss how some adults who attended his clinic were involved in risk taking behaviours and how any children in these families could be safeguarded. This has now been incorporated into the department's safeguarding care pathway.
- 5.3.6 Health visitor teams told us they value this training along with the use of a level 3 training passport developed in-house by the county-wide safeguarding training group. An example of what this provides them with is top-up master classes on the signs of safety model.
- 5.3.7 Looked-after children's specialist nurses have undertaken appropriate levels of safeguarding training in line with guidance in *Working Together to Safeguard Children 2013*.
- 5.3.8 Nurse practitioners within CASH services are also trained to level three in safeguarding vulnerable children. Healthcare assistants (who do not have individual, unsupervised contact with children and young people) are trained to level two. Following discussion and agreement with the training provider, safeguarding training is provided over two half-day sessions at locations convenient to CASH practitioners. The first half-days training is aimed specifically at CASH practitioners and includes CSE awareness training and the second half-days training is multi-agency. This is in line with good practice. However, CASH practitioners do not receive structured, regular safeguarding supervision in accordance with statutory guidance. Advice and guidance is provided on an 'as and when required' basis but this is not recorded in client notes (**Recommendation 1.19**). This area for development has also been drawn to the attention of Public Health England and Cornwall Council.
- 5.3.9 At RCHT, the named doctor, the named midwife and the specialist midwife have not attended Level 4 safeguarding training. Also, robust supervision arrangements for the named midwife with the designated nurse have not been established, despite efforts by the designated nurse to formalise these. These are expectations which need to be met to ensure that named professionals are best support in their safeguarding governance and leadership roles and meet standards set under national guidance (**Recommendation 1.20**).
- 5.3.10 Performance of the RCHT in meeting their trajectory to ensure staff are appropriately trained in safeguarding children continues to improve. We heard how the trust is exploring ways to improve the quality and accuracy of its training data.

- 5.3.11 All adult mental health practitioners have completed level 2 safeguarding training. The trust's safeguarding lead has an expectation that all adult mental health practitioners will have undertaken level 3 multi-agency training in line with statutory guidance and the child safeguarding responsibilities of adult workers in their daily practice. However, this is not supported by the CFT corporate training curriculum and training targets set out in the monthly operational managers' training performance return. At the level of competency at which adult mental health practitioners are operating on a daily basis with highly vulnerable families and children, the current safeguarding training approach is not fully equipping practitioners to discharge their child safeguarding roles and responsibilities (**Recommendation 3.15**).
- 5.3.12 Overall, arrangements for safeguarding supervision in health services are variable and not all services are operating in line with statutory guidance and best practice although we did see some good practice. In health visiting, formal safeguarding supervision is provided in line with guidance using the signs of safety model as a framework. Records of discussions held in supervision about individual cases are entered on case records and are comprehensive with clear plans and outcomes. This is best practice. As health visitors select their own cases to bring for supervision, with the focus being child protection cases, there is a risk however, that other cases on the caseload are not being regularly reviewed by managers in supervision to ensure that all safeguarding concerns have been identified and addressed.
- 5.3.13 Children's safeguarding supervision remains underdeveloped within the RCHT. The trust cannot be assured that all practitioners working with vulnerable families are receiving regular, individual supervision that is recorded appropriately and filed in the patient record (**Recommendation 1.21**).
- 5.3.14 CFT's adult mental health practitioners have access to ad-hoc supervision which they value and multi-disciplinary team (MDT) meetings have an element of group safeguarding supervision to them. It is usual practice to record discussion of specific cases on the adult's case record but we did not see evidence of this in all cases we reviewed. Supervision arrangements are not robust overall however; and not compliant with *Working Together 2013*. This is recognised as an area for development by the trust's children's safeguarding lead who is developing plans to introduce effective supervision arrangements across the service. Intrinsic to these plans we are told, is the intention to revise the supervision template to include children's safeguarding as a standing item (**Recommendation 3.16**).
- 5.3.15 School nurses have good access to both scheduled and ad-hoc 1:1 safeguarding supervision. Supervision notes are kept in the child's records and in the cases we sampled, onward planning and actions were clear.

- 5.3.16 In Addaction's adult substance misuse service, supervision is not well structured and not recorded on the client's case record when individual cases are discussed in supervision (**Recommendation 4.8**). This area for development has also been drawn to the attention of Public Health and Cornwall Council.
- 5.3.17 The CCG designated nurse for safeguarding is providing supervision to the PCH safeguarding named nurse on a monthly basis in line with good practice. However, no supervision is in place for MIU staff. Nurse practitioners at both MIUs visited were not receiving structured or regular safeguarding supervision, this despite them regularly referring cases to the MARU. At Camborne and Redruth MIU clinical supervision is also not a regular, routine occurrence. Nurse practitioners can obtain ad-hoc advice from the named nurse for safeguarding and peer support from colleagues, but this does not take the form of formal advice and feedback and is not routinely recorded in client notes. This is a significant gap in ensuring frontline practitioners are well equipped and supported to discharge their safeguarding responsibilities and does not conform to statutory guidance (**Recommendation 2.7**).

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# Recommendations

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- 1. Kernow CCG and Royal Cornwall Hospitals NHS Trust should:**
  - 1.1 Ensure that midwives are effective in identifying opportunities for early support and intervention with vulnerable expectant women
  - 1.2 Ensure robust ante and post-natal pathways for midwifery and health visitor liaison are in place and that there is consistency in notification processes and equity of access for new mothers across Cornwall to appropriate support.
  - 1.3 Ensure that a record is made at ED reception of who is accompanying a child accessing emergency treatment and who has parental responsibility
  - 1.4 Ensure that ED documentation prompts staff to identify any children in the household of adults who present as a result of risk taking behaviours to ensure that any children at risk of hidden harm are identified
  - 1.5 Ensure sufficiency of paediatric expertise on the ED at all times
  - 1.6 Ensure a robust policy and protocol is in place to guide staff in responding effectively when a child or young person leaves the ED before being seen
  - 1.7 Work with Public Health and Cornwall Council and Addaction to ensure an effective referral pathway is in place for expectant mothers with substance misuse issues
  - 1.8 Consider the establishment of a forum for multi-agency discussion on expectant women with additional social vulnerability to facilitate the co-ordination of Early Help multi-agency support
  - 1.9 Work with Cornwall Council and Addaction to develop an effective care pathway for young people with substance misuse issues to access prompt and appropriate support.
  - 1.10 Work in partnership with Cornwall Council to develop a robust joint protocol to govern pre-birth and discharge planning to ensure vulnerable unborn children are protected effectively
  - 1.11 Ensure that in making referrals to MARU, practitioners articulate their concerns and expectations clearly to best facilitate decision making about the priority and level of support a family needs and that quality assurance processes are in place

- 1.12 Ensure case records in all services are comprehensive; able to provide an audit trail of actions taken; include case chronologies as appropriate and subject to effective recording practice governance and monitoring arrangements
- 1.13 Ensure effective monitoring of practitioner attendance and report submissions to child protection and CIN meetings
- 1.14 Take action to improve direct liaison and information sharing between health professionals engaged with vulnerable and at risk children outside of formal processes in order that this increasingly becomes established and routine practice
- 1.15 Ensure that the Children in Care Health Team seek information from GPs and CAMHS as appropriate to ensure looked-after children's health assessments and reviews are fully informed
- 1.16 Ensure that strengths and difficulties questionnaires fully inform looked-after children's health reviews and that young people are given opportunities to evaluate their own emotional growth over their time in care
- 1.17 Ensure an appropriate allocated health care professional is identified when a child with known health needs is no longer a looked-after child to ensure clear ongoing case responsibility
- 1.18 Ensure compliance with statutory and Intercollegiate safeguarding guidance; that there is sufficient capacity for the safeguarding team to provide effective leadership and deliver robust governance arrangements to frontline services
- 1.19 Ensure that CASH practitioners receive planned structured, regular safeguarding supervision in line with best practice and statutory guidance as set out in *Working Together to Safeguard Children 2013*.
- 1.20 Ensure that named safeguarding professionals undertake safeguarding training to the appropriate level and that they are supported through robust supervision arrangements in line with statutory guidance
- 1.21 Ensure that robust safeguarding supervision arrangements are in place for all practitioners working with vulnerable children and families in line with statutory guidance and recognised best practice

## **2. Kernow CCG and Peninsula Community Health should:**

- 2.1 Ensure that MIU documentation prompts staff to identify any children in the household of adults who present as a result of risk taking behaviours to ensure that any children at risk of hidden harm are identified

- 2.2 Ensure effective staff supervision and observation of children and young people accessing the minor injury units in appropriate physical environments
- 2.3 Ensure effective operational monitoring of safeguarding practice in minor injury units to ensure best safeguarding practice
- 2.4 Ensure that in making referrals to MARU, practitioners articulate their concerns and expectations clearly to best facilitate decision making about the priority and level of support a family needs and that quality assurance processes are in place
- 2.5 Ensure sufficient capacity in PCH's safeguarding leadership team to provide effective leadership and to ensure robust child safeguarding governance arrangements are in place
- 2.6 Raise the profile of the healthcare provided to children across PCH and ensure a Think Family Model is embedded to facilitate effective child safeguarding practice in all services
- 2.7 Ensure that robust child safeguarding supervision arrangements are in place for all practitioners working with vulnerable children and families in line with statutory guidance and recognised best practice

**3. Kernow CCG and Cornwall Partnership NHS Foundation Trust should:**

- 3.1 Promote effective co-operative working between CAMHS and the children's substance misuse service through regular joint meetings to give opportunities to explore common issues and promote joint learning
- 3.2 Ensure that face to face handover of cases between school nurse and health visitor services take place routinely
- 3.3 Ensure that practitioners are proactive in ascertaining dates of Child in Need (CIN) and child protection meetings and outcomes when they are engaged with a case
- 3.4 Ensure that in making referrals to MARU, practitioners articulate their concerns and expectations clearly to best facilitate decision making about the priority and level of support a family needs and that quality assurance processes are in place
- 3.5 Ensure case records in all services are comprehensive; able to provide an audit trail of actions taken; include case chronologies as appropriate and subject to effective recording practice governance and monitoring arrangements

- 3.6 Ensure that adult mental health documentation contains appropriate prompts and templates to support practitioners in discharging their safeguarding responsibilities in line with best practice
- 3.7 Ensure an appropriate DNA policy and protocol is in place to support effective risk assessment and decision making by practitioners in order to protect vulnerable children
- 3.8 Ensure that the complete child protection, CIN and TAC plans are uploaded onto case records in order that the practitioner and managers have a full understanding of the plan and the roles and responsibilities of other services in protecting the child as well as their own
- 3.9 Take action to improve direct liaison and information sharing between health professionals engaged with vulnerable and at risk children outside of formal processes in order that this increasingly becomes established and routine practice
- 3.10 Ensure that parenting capacity is routinely considered in contingency and relapse planning in the mental health services
- 3.11 Ensure that mental health relapse indicators and contingency plans are routinely shared with other professionals engaged with the family with the agreement of the adult service user
- 3.12 Ensure that where CAMHS are working with a looked-after child, there is effective liaison and information sharing with the CIC health team to ensure the child's emotional health needs are well understood and inform their review health assessments
- 3.13 Ensure that the adult mental health service can easily identify the cohort of cases with children subject to CIN and child protection plans to facilitate robust governance of safeguarding practice, caseload management and workforce development
- 3.14 Put in place a strategy and implementation plan encompassing systems, governance and practice to ensure a Think Family Model is embedded in all adult services to facilitate effective child safeguarding practice
- 3.15 Ensure that the corporate training curriculum and training targets are aligned with statutory guidance and recognised best practice.
- 3.16 Ensure robust child safeguarding supervision arrangements are in place for all practitioners working with vulnerable children and families, including adult mental health, in line with statutory guidance and recognised best practice
- 3.17 Ensure that notifications to health visitor and the school nurse service for follow-up to a child's attendance at the ED are acted upon

- 3.18 Ensure a robust care planning system is in place across health visitor services with outcome focused goals which enable practitioners and managers to evaluate the impact of interventions
- 3.19 Ensure robust ante and post-natal pathways for midwifery and health visitor liaison are in place and that there is consistency in notification processes and equity of access for new mothers across Cornwall to appropriate support.

**4. Addaction should;**

- 4.1 Work with midwifery services to ensure an effective referral pathway is in place for expectant mothers with substance misuse issues
- 4.2 Work with the Royal Cornwall Hospital Emergency Department to develop an effective care pathway for young people with substance misuse issues to access prompt and appropriate support.
- 4.3 Ensure that all risk assessment processes clearly demonstrate that risks to children's health and wellbeing have been fully considered.
- 4.4 Ensure that in making referrals to MARU, practitioners articulate their concerns and expectations clearly to best facilitate decision making about the priority and level of support a family needs and that quality assurance processes are in place
- 4.5 Ensure case records are comprehensive; able to provide an audit trail of actions taken; include case chronologies as appropriate and subject to effective recording practice governance and monitoring arrangements
- 4.6 Take action to improve direct liaison and information sharing between health professionals engaged with vulnerable and at risk children outside of formal processes in order that this increasingly becomes established and routine practice
- 4.7 Ensure that relapse indicators and contingency plans are routinely shared with other professionals engaged with the family with the agreement of the adult service user
- 4.8 Ensure robust child safeguarding supervision arrangements are in place for all practitioners in line with statutory guidance and recognised best practice and that where cases are discussed in supervision, this is routinely noted on the case record.

**5. Kernow CCG working in partnership with Cornwall Council and the LSCB, should;**

- 5.1 Ensure that there are effective operational and strategic governance arrangements in place to monitor frontline operational safeguarding practice and multi-agency working that delivers good outcomes for children and young people
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## Next steps

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

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