

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

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

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CCGs included:	NHS Nene CCG NHS Corby CCG
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Summary of the review

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

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

About the review

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

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

How we carried out the review

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

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

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

In total, we took into account the experiences of 118 children and young people.

Context of the review

Levels of deprivation in Northamptonshire are fairly low, with the County ranking 48th of 149 Local Authorities in England. There are, however, significant variations across the County, with Northampton having 20.9% of children living in poverty, whereas in South Northamptonshire only 6.5% do. Overall there were 22,935 children across Northamptonshire living in poverty in 2011. With regard to obesity, the Joint Strategic Needs Assessment (JSNA) reports that 17.6% of Year 6 children in Northamptonshire are obese compared to an England wide rate of 19.2%. It should be noted that Northamptonshire's figure in this regard has increased in recent years.

Northamptonshire has 75 GP surgeries situated in nine localities – Daventry, South Northamptonshire, Kettering, Northampton Central, Northampton South and East, Northampton West, East Northamptonshire, Corby and Wellingborough.

Children and young people make up 24.8% of Northamptonshire's population with 18.6% of school age children being from a minority ethnic group in March 2014 according to ChiMat data. As at the 2011 census, 14.3% of Northamptonshire's residents were from ethnic minority communities. For schoolchildren, this figure rises to 17.2%, the largest group being White Other (4.7%) which includes people from European Union Accession states. There are also significant Asian (3.7%) and Black (2.4%) populations.

Overall, the health and wellbeing of children in Northamptonshire is mixed compared with the England average. Infant and child mortality rates are similar to the England average (ChiMat).

Immunisations for MMR were better than the England average both for first and second doses. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is also better than the England average.

ED attendances for children aged 0-4 years of age was significantly better than the England average, with 308.5 attendances per 1,000 children compared to 510.8 attendances for the average.

Obesity rates amongst children aged 4-5 years were slightly below the national average (8.7% compared to 9.3%) with obesity amongst children aged 10-11 years was better still, 17.2% compared to England average of 18.9%.

Statistics for teenage mothers and breastfeeding are similar to the England average, showing 1.5% of women giving birth were under the age of 18, compared to an England average of 1.2%. 72.9% of mothers began breastfeeding at birth, compared to the average of 73.9%.

Admissions to hospital for mental health conditions and as a result of self-harm were both significantly higher in Northamptonshire than the England average.

Northamptonshire had 260.4 admissions for mental health conditions per 100,000 children, compared to the average of 87.6. For self-harm, this figure was 419.3 compared to 346.3. Admissions for alcohol specific conditions were lower than average but admissions due to substance misuse were higher. NHS Nene CCG reports that the numbers admitted to hospital over the last 4 years have reduced (though there is a concerning increase in children aged 11–16 presenting).

Commissioning and planning of most health services for children are carried out by NHS Nene CCG and NHS Corby CCG and NHS England South Midlands Area Team.

Commissioning arrangements for looked-after children's health and designated roles are the responsibility of NHS Nene CCG and NHS Corby CCG and the looked-after children's health team, operational looked-after children's nurse/s, are provided by Northamptonshire Healthcare NHS Foundation Trust

Acute hospital services are provided by Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust

School nurse services are commissioned by Public Health Northamptonshire County Council and provided by Northamptonshire Healthcare NHS Foundation Trust

Health visitor services are commissioned by NHS England and provided by Northamptonshire Healthcare NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by NHS England provided by Northamptonshire Healthcare NHS Foundation Trust.

Child substance misuse services are commissioned by Northamptonshire County Council and provided by CAN.

Adult substance misuse services are commissioned by Northamptonshire County Council and provided by Crime Reduction Initiatives (CRI)

Child and Adolescent Mental Health Services (CAMHS) are provided by Northamptonshire Healthcare NHS Foundation Trust.

Specialist facilities are provided by Northamptonshire Healthcare NHS Foundation Trust, Northampton General Hospital NHS Trust and Northamptonshire County Council.

Adult mental health services are provided by Northamptonshire Healthcare NHS Foundation Trust.

The last inspection of health services for Northamptonshire's children took place in March 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The contribution of health agencies to keeping children and young people safe was found to be good and the Being Healthy outcome area was found to be adequate. Recommendations from that inspection are covered in this review. Northamptonshire also took part in a joint pilot inspection of multi-agency arrangements for protection of children in January 2013.

Northamptonshire's Multi-Agency Safeguarding Hub (MASH) became operational with Children's Social Care, Police and Health in August 2013. The co-located MASH team now consists of Children's Social Care, Police, Education and Health professionals. There are established links with a number of virtual partners such as Probation, East Midlands Ambulance Service and the Crime Reduction Initiative.

The report

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

What people told us

A young mum told us;

"I wouldn't be where I am today without my FNP nurse. I would still be stuck in a violent relationship. She helped put me in touch with people who helped get me out. I can't fault her."

A 14 year old boy on a paediatric ward told us;

"The nurses are good, they are always around. I was in lots of pain last night, they came and sat with me and reassured me until I fell asleep."

Parents of an infant on a paediatric ward with a leg fracture told us;

"Everyone has been really good. Staff have been brilliant, they introduce themselves and tell us their name".

Parents of an infant on a paediatric ward told us;

"If the ward is full there aren't enough staff to help you, especially on a Thursday, you don't want anything to happen to your child on a Thursday."

Parents of an infant being tube fed on a paediatric ward told us;

"It isn't fair. Because she isn't in the right area she can't get help. If she isn't at risk of aspiration then the tube can come out and she can feed as a baby should."

A young parent told us;

"I saw the FNP (Family Nurse Partnership) late in my pregnancy as the service was very new. I thought I would be patronised and made to feel like I couldn't cope. I did agree to be seen, but I was dreading it. It was brilliant. I was worried about actually giving birth. She answered all my questions and I knew exactly what to expect. This is a brilliant service. I am coping quite well."

Young people engaged with the Family Nurse Partnership also told us;

“It’s been a very good experience. She is helpful and non-judgemental. I liked doing the worksheets as it meant I was well and truly prepared. Anything that wasn’t included that I needed, she got for me as soon as I texted her”.

“We would have struggled a lot more than we have. She has helped us so much. Shown us what was safe and what was unsafe and gave us ways to de-stress and be calm so that it didn’t affect the baby.”

A young person involved with CAMHS told us;

“Consistency of worker is important. The environment should not be so clinical. It would help young people open up more. I did feel listened to and I was always seen alone when I wanted to be.”

A young person involved in Young People’s Healthwatch told us;

“I was seen really quickly at A&E. I was treated very well and the doctor and nurse were very caring. They explained everything to me and that was really good.

At school there is a weekly lunchtime drop-in with the school nurse. It is a really good thing but some young people might be put off by it being in a school environment.”

The child's journey

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

1. Early help

- 1.1 Midwifery services are provided by both Northampton General Hospital NHS Trust (NGHT) and Kettering General Hospital NHS Foundation Trust (KGHFT). The majority of newly pregnant women book their pregnancy early at the GP practice. All GP practices have a dedicated midwife and bookings take place primarily either at the GP surgery or the local children's centre. In all cases seen midwives were accessing the woman's GP record to ensure that any relevant social or medical history is considered at booking.
- 1.2 We saw evidence of midwives being vigilant to expectant women not attending for their ante natal care. This includes sending letters, making telephone calls and scheduled and opportune home visits. This ensures that women are actively encouraged to remain engaged in their ante natal care and helps to protect the unborn child. We saw good joint working and links between the two acute trust midwifery teams on cases where the expectant mother might attend either department.
- 1.3 However, consideration of vulnerability of expectant women and safeguarding the unborn child is not sufficiently robust and it is not clear that there is recognition that safeguarding is everybody's business across all levels of the midwifery services. There is no routine risk assessment that sufficiently explores social vulnerability and any associated risk. Instead there is an over reliance on practitioners' knowledge and understanding and recording this as free text in the patient record. Prompts and trigger questions within a standardised risk assessment proforma encompassing potential social vulnerabilities and risks help to promote consistent good risk assessment practice. In the absence of this, there is a risk that not all potential risks may be considered and we saw cases where midwives were not routinely identifying or responding to risk appropriately. We also found no evidence of risk assessments being routinely revisited during the pregnancy which is a period when vulnerabilities and risks may emerge or increase. (**Recommendations 1.1 and 2.1**)

- 1.4 Expectant women are not routinely seen alone at booking and often the routine question around domestic violence is not asked. This is not good practice and is a feature of serious case reviews. Research shows that the risk of domestic violence can increase in pregnancy. This lack of opportunity to disclose issues that the woman may not want her partner to hear means that opportunities to safeguard the woman and unborn child may be missed. **(Recommendations 1.2 and 2.2)**
- 1.5 Midwives in KGHT use a new maternity IT recording system which incorporates enhanced recording of partner details; this is learning from a serious case review (SCR) and we saw increasing compliance as the new IT record rolls out to all new bookings, demonstrating that practice in this area is strengthening. In the NGHT midwifery service however, risks associated with paternal health and lifestyle choices that may have an impact on the unborn/new-born are not always asked and recorded at booking in. **(Recommendation 1.3)**
- 1.6 Given the rural nature, size of the county and parking costs at both acute hospitals, co-ordination of midwifery and other hospital appointments where possible would reduce the risk of vulnerable mothers-to-be not attending for key ante-natal checks. We saw one case example where a vulnerable expectant mother had not attended (DNA) a midwifery appointment as she had attended the hospital for another appointment at the diabetes clinic the day before. **(Recommendations 1.4)**
- 1.7 Facilities for children and young people under 10 are well developed at Northampton General ED. There is a separate waiting area for children who are fully observed by the nurses on duty and a designated Paediatric ED area. All under 18's are seen in Paediatric ED, however there is not fully adequate facilities for the 16-17 year olds in that area and a parent did comment to us that she was unsure whether adolescents should be in that area with younger children.
- 1.8 The paediatric ED at Kettering General Hospital consists of a small size waiting room that adjoins a four bedded treatment area. If the door to the treatment area is closed, then waiting children cannot be observed and this creates some risk which the trust should address. We were told that there are existing plans to remove the dividing wall between the two areas. **(Recommendation 2.4)**
- 1.9 At the emergency department (ED) at Kettering General Hospital, receptionists check the demographic details of all children and young people who attend and record these on the ED patient record. However, they do not routinely record the name of the next of kin and the name of parents. At Northampton General Hospital, the child's next of kin is recorded but not the identity of the adult accompanying the child. **(Recommendations 1.5 and 2.5)**

- 1.10 At both hospitals' EDs, electronic flags alert ED practitioners to Northamptonshire children who have a child protection plan in place and this helps inform ED practitioners' risk assessment.
- 1.11 Currently, neither Northampton nor Kettering General Hospitals, have separate paediatric ED documentation in place, that incorporates an effective safeguarding triage for practitioners to complete, and this is a gap. Kettering General Hospital had already identified this as a gap and discussions were underway to rectify this. At Northampton General Hospital, a safeguarding, five question sticker is used in some paediatric injury cases, but not all. The lack of provision of discrete paediatric documentation in the EDs is not adequately supporting practitioners to routinely consider and document child protection concerns fully in their day-to-day practice, in a busy and pressured environment. Safeguarding risk assessment in the EDs is currently over reliant on the knowledge, expertise and alertness of the clinician to consider all potential risks without the benefits of prompts within the assessment proforma to steer their practice. This significantly weakens the approach to safeguarding risk assessment and is not suggestive of effective governance arrangements.
- 1.12 While both hospitals' IT systems identify the number of previous attendances at ED, we saw how repeat attendances by children and young people at KGH were not always being considered as part of the assessment of a presenting condition. This is not good practice and is a feature of serious case reviews. (**Recommendations 1.6 and 2.6**).
- 1.13 We did see the successful introduction of a robust process for identifying potential risks for any baby under 28 days old who is brought to the ED, including checks made with maternity safeguarding for any concerns that may have been identified in pregnancy. This is good practice.
- 1.14 At Northampton General Hospital and adjacent to the ED, there is a GP led front door service called IC24. Under the current IC24 triage system all patients presenting at ED are triaged by a navigation nurse from IC24. Paperwork in both IC24 and the ED is not compliant with guidance and best practice and we saw examples of poor safeguarding risk assessment at IC24. This was of concern as we did not find that governance arrangements for IC24 safeguarding practice were robust (See section 5.3 of this report).

Case example: *A 6 month old baby was brought into ED by the parent. The baby presented with a head injury following falling out of a buggy. The infant was triaged and discharged home by the IC24 service. No information was recorded around the nature of the injury and no comprehensive risk assessment or probing of the circumstances leading to the injury was seen in the record.*

Very shortly afterwards, the parent returned to the ED as the baby had deteriorated and seemed poorly. The baby was seen by ED this time and was admitted to the paediatric ward overnight as per the head injury protocol as a precaution.

Paediatric ward staff were able to evidence their follow up and further detail about the injury was ascertained and recorded. There were no safeguarding concerns in this case, but this had not been ascertained and/or recorded at the initial triage.

- 1.15 Children are triaged quickly by appropriately trained staff at both EDs and we saw good liaison with social workers to share information on presentations seen in all cases sampled. This was for both local children and for those from outside Northamptonshire. Staff are clear on how to articulate and action their concerns around safeguarding to the appropriate people. We have seen many examples of ED staff liaising and following up actions and information sharing with health visitors, GP and social workers.

Case example: *A 15 year old female presented at ED after taking drugs and experiencing 'legal highs', was treated and discharged. No referral was made to the young people's substance misuse service as this pathway was not in place.*

On reviewing the under 18's list of presentations to the ED as per routine practice at the trust, the safeguarding nurse noted the young person's address and knew it was a children's social care residential home. On querying why the young person had not been identified by the ED for follow up as per usual process for looked-after children in the county it transpired that the young person had been placed in Northamptonshire from another local authority and therefore the child had not been not flagged on the hospital electronic system.

The safeguarding nurse followed up promptly, informing the young person's placing authority of her presentation. This demonstrates the diligence of the safeguarding nurse as well as the benefits of a daily review of all under 18 ED presentations to ensure that no safeguarding issues are missed.

- 1.16 All presentations of infants under 12 months old and all fractures in children under 2 years are reviewed by a paediatric consultant at NGH. An effective local safeguarding children's board (LSCB) bruising and head injury protocol is in place. These protocols are in accordance with best practice and national guidance. There is no formal head injury protocol for children and young people at Kettering General Hospital however, therefore the department is not compliant with guidance or the LSCB expectations.
(Recommendation 2.7)
- 1.17 We saw a lack of professional curiosity at Kettering General ED in some cases. In one case, several incidents resulting in injury to the child had occurred in the early hours of the morning. However, there was no evidence that clinicians had given consideration about the time and circumstances surrounding these incidents; no paediatric liaison form was completed and there was no consideration of previous attendances. It is worth noting that these events were prior to the appointment of the new paediatric liaison nurse, whose appointment has made a positive impact on practice.
- 1.18 Young people have good access to integrated contraception and sexual health (CASH) and sexual health services across the county provided by integrated sexual health (ISH) and school nurses. School nurses have been successful in securing sexual health support to young people in all secondary schools in the county through their weekly drop-in clinics. ISH have a clear website which enables young people to be informed on where and when clinics are available. This is particularly useful in rural areas. Evaluations of the clinics demonstrate a very high level of satisfaction with the ISH service. A comprehensive assessment tool is in place for all under 18's and also used for vulnerable older teenagers. There is thorough questioning and analysis of risks around child sexual exploitation CSE and coercive relationships, with onward referrals to the RISE sexual exploitation team if appropriate.
- 1.19 A child and adolescent mental health (CAMHS) community liaison service has been established to work with schools and school nurses to strengthen primary care-based help to young people needing lower levels of support for emotional health and wellbeing. An advice and consultation line for professionals has also been set up which will contribute to a developing early help offer which is not strong currently in Northamptonshire. The new ADHD and ADSD team is operational and has been established in response to identified need, facilitating earlier access to assessment and support for this cohort of young people.

2. Children in need

- 2.1 Overall, we saw that midwives are working hard to improve communication and information exchange with health visitors, however there is some way to go before good practice is consistent across Northamptonshire and becomes embedded. A pilot project was taking place in Corby at the time of this review, trialling joint meetings between health visitors and midwives to discuss vulnerable families and also joint areas for development. Where we have found these multi-disciplinary meetings established in other areas, these can be highly effective in improving inter-service understanding and communication and most importantly, in helping to engage vulnerable families with support at an early stage. Initial feedback from the pilot was that practitioners were finding it useful.
- 2.2 Arrangements where midwives are based in GP cluster surgeries facilitates co-working and opportunities to liaise regularly with GPs. However, currently there is no provision for routine multi-agency psycho-social forums in the midwifery services to discuss vulnerable pregnancies and facilitate access into early help provision. Where we have seen these established elsewhere, they are considered highly effective by participants in identifying and addressing vulnerabilities early and we have seen evidence of very positive outcomes for mothers and babies, particularly where social care have participated regularly. (**Recommendations 1.7 and 2.8**)
- 2.3 Following learning from an SCR, a standard operating procedure (SOP) is in place setting out that all midwives must notify health visitors of pregnancy and vulnerability for a woman at an early stage of pregnancy. Health visitor liaison forms have been developed to meet this expectation. However, we found that these are not routinely copied into maternity notes at NGHT and we found that the liaison forms are not always being received by health visitors. It is not clear therefore that detailed information gathering and analysis of vulnerabilities is being shared appropriately to ensure holistic care planning and safeguarding of unborns. (**Recommendation 1.8**)
- 2.4 In the NGHT midwifery service, vulnerabilities below the local authority's child protection threshold (level 4) are included in the core community service, and we saw significant variability in how or if these vulnerabilities were identified, as reported above. Cases we reviewed highlighted significant gaps in risk assessment and identification or further exploration of vulnerabilities. Where vulnerabilities are identified, these are flagged to the trusts' safeguarding team. Subsequent care planning in the service where there are known concerns, is not sufficiently robust, however. Women are not routinely receiving the 36 week home visit creating a high risk that the only home visit will take place 1 day after hospital discharge. New mothers are not being well supported in the immediate post natal period by being asked to attend the children's centre to access their midwife. (**Recommendation 1.9**)

- 2.5 There are no specialist midwives for vulnerabilities for cases assessed as being under the threshold for child protection. There is also a significant gap in support arrangements for teenage pregnancy with no agreed care pathways for teenagers who are pregnant or have mental health and substance misuse issues. Support for teenage parents in Northampton was recently reduced with the cessation of the parent craft group which operated there. **(Recommendations 1.10 and 2.9)**
- 2.6 Support for pregnant women with substance misuse problems who do not meet the highest threshold of need is underdeveloped. Although adult mental health practitioners told us that they felt that they are routinely involved in pre-birth and discharge planning with midwives. We found that liaison between midwives and both adult substance misuse workers and adult mental health practitioners, is often ad-hoc rather than routine practice. The provision of specialist roles in the midwifery service would help drive improvement in the provision of support to expectant women, including teenagers, identified as vulnerable. **(Recommendations 1.10 and 2.9)**
- 2.7 In both midwifery services, common assessment frameworks (CAFs) are underutilised and in case examples we saw, are not outcome focused. Take up by expectant women is low with many declining the offer. It is not clear how effectively the potential benefits of CAF are being promoted by practitioners in midwifery and health visiting. In the absence of any other midwifery service health plan, specific to type of vulnerability and since the cessation of use of the cause for concern forms in 2014 since the last joint inspection, practitioner roles and responsibilities are not always clear. As a result, women and babies may not always be fully and effectively supported. **(Recommendations 1.11, 2.10 and 3.1)**
- 2.8 In cases stepped down from child protection or that do not meet the child protection threshold, we did not see clear, explicit and well-co-ordinated Child in Need (CIN) plans and it was not always clear who “holds the ring” on a particular case. While children's social care have the lead responsibility to ensure that plans are in place and that health and other partners receive CIN plans, it is essential that health practitioners leave multi-agency meetings clear on what the plan and their role in it is and that they ensure they have robust CIN plans on their client record to over-arch their own care planning.

- 2.9 We did not see discrete and clearly identifiable care plans in cases across health services, including CAMHS. Plans for working with the child and family are routinely set out within contact running records. This does not ensure that interventions are explicitly inclusive of the child's goals and that progress monitoring and evaluation of the effectiveness of intervention is facilitated. In cases where the child is subject to a CAF, CIN or child protection plan it is essential that these are underpinned by robust care planning. This is not currently in place. Managers have recognised that this is an area for development and we understand that there are plans to develop a generic care plan format to be used across the new integrated children's service in NHFT. A task and finish group has been set up to develop an integrated assessment and care planning format. **(Recommendations 1.11, 2.11 and 3.2)**
- 2.10 There is no dedicated specialist perinatal mental health pathway and arrangements for mothers-to-be with mental health needs, particularly low to moderate needs, are underdeveloped. There is no consultant psychiatrist responsible for the pathway. This is not compliant with NICE guidance. Women who have history of mental health problems have access to a consultant obstetrician's as part of general vulnerability but this does not constitute sufficiency of specialist support as set out in the guidance. The lack of access to mental health services is a particular concern for midwives and health visitors working with women with mental health issues. Due to a change in the referral protocol, midwives are no longer able to refer expectant women directly to mental health services instead they are asked to refer the woman back to the GP to facilitate the referral. Where the woman is being cared for by the KGHT vulnerable women's team, then we saw evidence of joint working with other professionals, including adult mental health services, however for women with mild to moderate mental health need who do not meet this threshold of need, we saw no follow up by community midwives on the progress or uptake of any referrals to mental health services.
- 2.11 Mothers in either ante-natal or post-natal periods who are inpatients on maternity wards due to clinical need, can access an enhanced mental health service via the adult mental health team although this does not constitute a specialist perinatal service. This mental health provision is not available in the same way for mothers in the community who may have mental health needs however, demonstrating an inequity of access to mental health support. The absence of any specialist midwives for mental health and specialist consultant psychiatrist led perinatal mental health service in Northamptonshire risks expectant mothers not being supported effectively with their mental health needs to the potential detriment of themselves and the health and wellbeing of their baby. **(Recommendation 3.3)**

- 2.12 Emergency department practitioners at both acute hospitals do not routinely record details of children who are involved with adults who attend through concerning behaviours; including those adults with mental health problems and domestic violence. This is despite the presence of prompts on the paperwork at Northampton General, which are not consistently completed. The paperwork at Kettering General had no specific prompts or space to record this important detail. Think Family is not well embedded in acute services and paperwork and lack of compliance across both acute sites does not aid effective risk assessment for children who may experience hidden harm. **(Recommendations 1.12 and 2.12)**
- 2.13 The provision of paediatric liaison forms after a child has attended EDs to facilitate information sharing and follow-up in the community is a positive development. However, at Northampton General, we learnt that these are not always reaching school nurses. **(Recommendation 1.13 and 3.4)**
Public Health at Northamptonshire County Council has been made aware of this area for development.
- 2.14 Where regular liaison meetings to share information on vulnerable families have been established in GP practices, involving health visitors and school nurses, these are helping to ensure effective follow-up in the community and to promptly identify families who would benefit from early help support. However, these meetings are not established in all GP practices countywide. **(Recommendation 4.1)**
- 2.15 There is a lack of clarity in the two EDs around access and making referrals to CAN, the young people's substance misuse service, and we did not see evidence of young people being referred for support. **(Recommendations 1.14 and 2.13)**
- 2.16 Children and young people who attend both EDs following an incident of self-harm are supported through a multi-agency agreed care pathway. A separate set of notes are created to supplement the ED record and follow the child throughout their episode of care and include the CAMHs assessment, care planning, discharge and a safety plan and information sheet for parents and young people. The effectiveness of this potentially highly effective pathway is compromised by practitioners not fully completing documentation, including the safety plan and not routinely sharing the advice and guidance sections with parents and young people. **(Recommendations 1.15 and 2.14)**

- 2.17 There is a responsive CAMHS assessment service available for young people presenting in crisis at both the EDs. The CAMHS service makes daily phone contact with the ED/paediatric wards at Northampton and Kettering General Hospitals. This is good practice, facilitating prompt access for young people in mental health crisis to a CAMHS assessment. Children are admitted to the paediatric wards, where appropriate, for a period of cooling off and observation whilst waiting for assessment by CAMHS and this is also good practice. Often these children will be cared for in the high dependency bay because ward staffing allocation means that they will be under closer supervision in this area. We heard how it is often difficult to rapidly obtain authorisation and source additional staff to observe these children who often needed more intense support and observation.
- 2.18 Paediatric ward staff report a good relationship with CAMHS and told us that they can access support and advice in how best to support young people. However, there are not individual written plans led by CAMHS, in conjunction with paediatric staff, put in place to manage the care and support to the young person while they are on the paediatric ward. The lack of these plans creates risk that young people in mental health crisis or at risk of serious self-harm are not fully supported on the paediatric ward and risks of serious incidents minimised. (**Recommendations 1.16, 2.15 and 3.5**)
- 2.19 After initial assessment, CAMHS offer a range of interventions. Skills based workshops are offered to young people who self-harm. There is a managing behaviour with attachment in mind course to support carers of children looked after. There is also a recently developed service which provides access to specialist assessment and support for children and young people who have neurodevelopmental needs. When engaged with the CAMH, we saw evidence that young people experience beneficial outcomes from the therapeutic interventions. We saw case evidence however, of young people experiencing further emotional ill health in the often lengthy period of time between CAMHS assessment and the start of core service intervention. The skills based workshops, which are provided during this period, go some way to support children and families and in some cases, and can fully address the child's need for mental health support. The access to timely CAMHS interventions for young people in Northamptonshire remains an on-going challenge to commissioners and providers

Case example: A young person aged 14 years waited six months following assessment by the service before they were able to start their 1:1 engagement with an allocated practitioner. The young person and his parents had been informed of the likely wait.

During this period, the young person identified an increase in suicidal thoughts and his parents were able to access urgent support through their GP who re-referred him as needing urgent intervention. As a result, CAMHS were able to offer some short term intervention which reduced the child's level of risk of self-harm.

The child's appointment was also moved earlier. Since engaging with the service, the child's needs have been met well and he has become much less likely to harm himself. His parents told us that they also have felt very well supported since CAMHS engaged with the family.

- 2.20 Northampton has a number of Eating Disorder in-patient beds on the Sett, which is a general children and young people's mental health ward, and will only admit young people out of area when these are full. When young people need specialist in-patient treatment for an eating disorder their admission is managed by NHS England on demand.

Case example: A young person with a serious eating disorder was admitted to an acute paediatric ward. While an in-patient, she was being supported on the ward by a practitioner from the CAMHS Crisis Team 2-3 hours per day to support her particularly over meal times and to support the paediatric staff.

This was beneficial in helping the young person and ward staff to cope with her disorder at particularly stressful times. It has also been beneficial in providing reassurance to the young person's parents about the support to the family while plans are being developed for ongoing support and/or potential specialist in-patient placement is identified.

- 2.21 Both GP practices visited use SystmOne information and patient record system and this aids the GP's ability to work collaboratively: exchange information with other health professionals working with vulnerable families and "task" each other for information or specific follow up actions. However we are aware that many practices in Northamptonshire do not use this linked system. The use of priority flags both within and across family notes to alert GP's to heightened vulnerabilities was in place in the practices we visited and this is good practice.
- 2.22 Both GP practices had limited awareness of multi-agency risk assessment conferences (MARAC) which focus on families where domestic violence is known to be an issue and neither practice routinely receive domestic violence notifications, therefore they are unable to offer follow up support to families who are victims of domestic violence. (**Recommendation 4.2**)

- 2.23 Both GP practices make good use of the safeguarding multi-disciplinary team meeting (in one case weekly, in another monthly). In the cases we sampled this had a very positive impact on ensuring children and families were appropriately supported.
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3. Child protection

- 3.1 The development of a MASH in Northamptonshire, implemented in August 2013, is positive. Health commissioners and providers are actively engaged in the development and improving operation of the MASH. The health partnership/rotating model of health professional and researchers is a sound approach; likely to drive continuous improved performance in health's contribution to safeguarding while supporting the health and wellbeing of practitioners effectively in working in what is often an intense and pressured environment. Health practitioners in the MASH would benefit from the use of headsets to promote their own health and wellbeing and facilitate operational practice.
- 3.2 The MASH health practitioners told us that most GPs and practice managers respond positively to enquiries from the MASH and respond promptly with the required information. The health practitioners attend GP forums regularly to help establish good relationships and the named GP has been instrumental in breaking down any blocks or barriers between primary care and the MASH, helping to establish this positive engagement.

Case example: *A 16 year old female with a history of self-harm who has a four week old baby and is living between her parents who are separated. She spends the week with Dad so that she can go to school, and weekends with Mum. The young person disclosed to the nursery that she was having thoughts of harming the baby. This was occurring when she was left alone at night with the baby as Dad was working nights. The nursery nurse contacted the health visitor who contacted the MASH health professionals.*

As a result of this prompt action on the part of all health practitioners involved, safeguards were put into place immediately. The young person now stays with her Mum and grandmother at night to support her and help her care for the baby. The nursery nurse was trying to obtain a CAMHS assessment for the young person while she was at school. A duty CAMHS worker informed the MASH they were unable to undertake the mental health assessment for a week. The MASH health practitioner was able to co-ordinate support from the health visitor service and the nursery nurse to provide daily support to the young person until the CAMHS assessment could be undertaken.

The young mother is being well supported by family and health professionals while awaiting an assessment of her emotional health and the baby has been protected.

- 3.3 Emergency department staff in both acute trusts are confident in identifying and referring child protection and safeguarding concerns to either paediatric liaison or to children's social care. Across health services, we saw appropriate referrals to children's social care and we were impressed by the quality of most referrals we saw; some of which were outstanding. Risks to the child and/or others, for the most part, were set out clearly and succinctly and the expectations of the practitioner in making the referral were also identified. Most practitioners demonstrate clear understanding and use of the thresholds and pathways document in formulating their referral. Overall, referrals to children's social care by Northamptonshire's health community are the best quality we have seen nationally to this point of the CQC Children Looked-after and Safeguarding (CLAS) review programme. This is highly commendable.
- 3.4 Midwives can refer concerns to children's social care at any time and there is a robust pre-birth protocol in place endorsed by the LSCB through which agencies can hold each other to account. Midwives are vigilant in ensuring women and children are discharged home at the earliest appropriate opportunity.

- 3.5 Expectant women who are identified as needing support at the highest level of need (Level 4 NCC threshold) i.e. child protection, are supported by dedicated team of vulnerable women midwives in KGHT and the central team in NGHT, who are reportedly more experienced in safeguarding and CP arrangements. The named midwives in the trusts provide good support to these specialist midwives, including case management reviews and planning. The plans we reviewed, however, were not SMART. **(Recommendations 1.17 and 2.16)**
- 3.6 Chronologies are not routinely used and this makes it difficult to establish significant key events. Lack of chronologies in complex cases is a common feature of serious case reviews. **(Recommendations 1.18, 2.17 and 3.6)**
- 3.7 All practitioners we spoke to across services, either attend child protection case conferences or submit reports. This is not best practice which would be to submit reports in advance of the conference as well as attending. By not completing reports for conference, this means that practitioners are not sharing the information to be presented to conference with families in a fully transparent way.
- 3.8 Record keeping in the specialist level 4 midwifery teams is poor. In some cases, this evidenced poor child protection practice which is of significant concern, particularly in specialist midwifery teams established to protect the most at risk and consisting of practitioners deemed to be the most skilled and experienced in child protection. Plans for women at level 4 were variable and were not easily located in the files. Some were robust but others had a lack of clear outcome focus and lacked confirmation that actions had been followed up. The named midwife at Kettering General Hospital reviews previous information held on files for all women referred to the vulnerable team. She often identifies significant historical information that has not been disclosed to the midwife who is working with the expectant woman. This has resulted in enhanced protection for the unborn child in those cases. We did not see minutes of conferences routinely stored on the case record and we were not always able to find out the content of discussion and contribution of these midwives to child protection conferences. **(Recommendations 1.19 and 2.18)**
- 3.9 Birth plans are produced to support child protection plans and those we saw were clear. However, they are not routinely copied to families and this may not be supporting families to best effect. **(Recommendations 1.20 and 2.19)**

- 3.10 Female genital mutilation (FGM) is deemed to be prevalent in Northamptonshire. We heard that the county is one of the top 10 areas for FGM in the country, identifying approximately 8 cases a month that meet the criteria for data collection project. An FGM policy is in place and midwifery services at NGH have supported a number of adult women who have undergone FGM. However, an ongoing community engagement initiative is being undertaken as communities have been reluctant to engage and have reportedly become “anti-establishment” regarding FGM. There are two midwives with special interest but no specialist midwife roles formally identified. Some staff had accessed training via level 3 master classes on this however there is more to do to robustly develop a consistent service that victims and communities are engaged with as a matter of urgency. **(Recommendations 1.21 and 2.20)**
- 3.11 Health visitors are well engaged with both formal and informal safeguarding measures and cases sampled highlighted good attendance at child protection meetings and core groups, along with a regular presence at GP MDT safeguarding meetings, where they exist.
- 3.12 Health visitors demonstrate strong persistence in some teams seeking information and updates on meeting dates, paperwork etc.; however there is a lack of awareness of how to escalate cases where there is professional disagreement. There is not an effective multi-agency escalation policy in place to support and guide staff when there are dissenting professional opinions. In some cases, practitioners raise concerns by re-referring multiple times, in the hope that they will be accepted. **(Recommendation 5.1) This issue has been drawn to the attention of Northamptonshire County Council and the LSCB.**
- 3.13 Liaison between health visitors and other services, including community midwifery as identified above under section 2. Child in Need, is an area of development and a feature across health services in Northamptonshire. We also heard that there can be barriers to communication and information sharing between children's social care and health visitors both on new and established cases which can impact on health visitors ability to fulfil their roles and responsibilities in CIN and child protection plans. This is particularly problematic with the limited use of service specific care plans which outline the health visitor unique contribution to families.

- 3.14 Capacity issues within the health visitor team, both from vacancies and high levels of sickness, are impacting on health visitors' ability to develop services, and undertake proactive rather than reactive case management. The limited nature of this service and other health services in joint working with CRI substance misuse and adult mental health teams, is a concern. We found no instance of joint visits or close working outside of formal child protection procedures in the cases that we reviewed. Regular communication and information sharing between disciplines on cases held in common does not commonly happen in Northamptonshire and this has been a feature in many serious case reviews nationally. **(Recommendations 1.22, 2.21, 3.7) These issues have been drawn to the attention of Northamptonshire County Council.**
- 3.15 There is variable practice in regards to children and young people who do not wait for treatment after registering at the EDs, protocols and practice across health services in Northamptonshire. At Northampton General Hospital, a policy for children at risk of absconding or going missing is in place, however descriptions of young people for whom this might be a risk are not recorded which would assist agencies in locating the young person should they go missing. All children and young people who leave the ED prior to treatment are flagged on the ED safeguarding list and a paediatric liaison form is completed by the safeguarding team for follow up in the community. Although, at Kettering General Hospital, staff routinely note the clothes and appearance of adults and children who attend the ED, we were told that practice is not guided and supported by a policy for children at risk of absconding or going missing and this is a gap. **(Recommendation 2.22)**
- 3.16 In the Northamptonshire Healthcare NHS Foundation Trust (NFHT) adult mental health service, a DNA policy and flow chart is in place and well established. However, does not encompass the need for the mental health practitioner to assess the risks to children identified as being at significant risk as CIN or being subject to child protection plan, as a result of an adult not attending appointment(s) and what safeguarding actions the practitioner should take in these circumstances. **(Recommendation 3.8)**
- 3.17 Adult mental health practitioners demonstrate clear understanding of the need to prioritise the safeguarding and protection of children while working with the parent. Practitioners are dogged in their efforts to engage clients who are often very difficult to engage. When working with adults whose children are subject to child protection plans, they report appropriately and promptly any non-compliance with child protection plans by the parent. They have little direct or regular communication and liaison with other health practitioners outside of formal processes, however. **(Recommendation 3.7)**

- 3.18 Of serious concern in adult mental health, is the lack of use of alerting flags on the electronic case records where practitioners know there are children at risk, including those on child protection plans. Cases only include alerts about the adult's self-harming behaviour or suicidality and this is unacceptable. Managers in the service are unable to identify the cohort of child protection cases within the service. This has implications across a range of areas: effective operational oversight to ensure children known to be at risk are clearly identifiable and protected by the service, being the most significant. This is a priority area for remedial action. The information system currently in use and not due to be replaced for some months, does not immediately identify children in the family or in the household on opening case records. Details of children are "buried" within the running record and therefore there is high current risk that these children will be, and are, lost sight of by practitioners and the service. We saw clear evidence where this is the case. While practitioners have an understanding of think family principles, systems and processes in place across the service are not supporting staff practice sufficiently. There is no explicit intention in the trust to establish the Think Family model in adult mental health which if applied as the service model, would help to ensure best child safeguarding practice in adult mental health. **(Recommendations 3.9 and 3.10)**
- 3.19 Health practitioners in Northamptonshire are not always precise in their use and recording of formal child protection terminology and we saw this particularly in CAMHS and health visitor services. This can lead to confusion or ambiguity in case records as to the exact status of a child and the level of risk which has been identified. Use of outdated terminology can also undermine other professionals' confidence in the health practitioner's knowledge and understanding of child protection processes. **(Recommendation 3.11)**
- 3.20 S2S is the local adult substance misuse service in Northamptonshire, provided by Crime Reduction Initiatives (CRI). S2S is working effectively to support adults with substance misuse and alcohol addiction living in the county. There are good IT assessment templates to aid practitioners in the identifying and recording of children with whom the adult service user may have contact and good risk assessment processes are in place. However, these are not routinely being completed. In most files reviewed, the voice of the child and the impact of the parental substance misuse on the health and wellbeing of the child was not being regularly considered. Record keeping on safeguarding and child protection was poor. It was not possible to easily identify if a worker had attended child protection, child in need or CAF meetings and what their contribution had. **These issues have been drawn to the attention of Northamptonshire County Council.**

- 3.21 S2S Workers are not actively contacting other health professionals working with parents and are often passive recipients of information rather than this contributing to any existing risk assessment or triggering a review of risk by the S2S practitioner. In cases where a worker had been supported by the service's safeguarding lead, there was a clear emphasis on the needs of the child in vulnerable families. However, this is not routine practice across the service generally. We saw no evidence of routine consideration of the potential impact on the child where a parent may be misusing substances or subject to a treatment programme involving a substitute medication such as methadone. Insufficient considerations of such risks by practitioners are a feature of serious case reviews. We also did not see evidence that safety plans which include consideration of child safeguarding are routinely discussed when a parent had relapsed and was misusing. **These issues have been drawn to the attention of Northamptonshire County Council.**
- 3.22 Health services across the county are generally well engaged with MARAC, MASH and RISE, which focuses on young people at risk of sexual exploitation, forums. CAMHS told us that they felt that did not routinely get effective information back from MARAC and assurance that actions to minimise risks had been completed by all agencies. We heard about liaison calls between ED staff at NGH with the RISE team to share information on attendances and there are good links and cohesive working between the ISH, CAN and RISE teams which is protecting young people at high risk of harm. The provision of an independent domestic violence advisor (IDVA) at KGH for 15 hours per week is a positive development.

4. Looked after children

- 4.1 Currently, 89% of looked-after children in Northamptonshire can expect to have an initial assessment (IHA) of their health needs within 28 days of coming into care. This marks a significant improvement in performance over recent months. Clinic provision has been increased to meet demand and currently, capacity is sufficient. The provision of a small team of specialist health assessors and co-location with other NHFT services and the provision of a CAMHS looked-after child service is also positive, facilitating focused support to this vulnerable cohort. The Atlas multi-agency meetings are a valued forum to promote effective multi-agency and multi-disciplinary support to looked-after children.
- 4.2 Initial health assessments (IHAs) are undertaken by appropriately qualified clinicians at both NGHT and NHFT but quality is variable and overall not high across both trusts. The voice of the child is not well evidenced. While there has been an audit of IHAs and one is planned for RHAs, there is not an effective ongoing quality assurance process in place, based on national standards, which also encompasses health assessment for young people placed out of area. (**Recommendations 1.23 and 3.12**)

- 4.3 Some IHAs lacked any birth and parental health history which can have a long lasting impact on young people as they leave care and enter adulthood. This is an issue for the health and social care partnership to address together as the only opportunity to ensure this information is gathered and transferred to health is at the point at which the child becomes looked-after. (**Recommendations 1.24 and 3.13**)
- 4.4 A number of IHAs lacked any information about ethnicity, language and religion, all of which have significant implications for how health care is best provided to young people from a range of ethnic communities. (**Recommendations 1.25, 2.24 and 3.14**)
- 4.5 Out of area placements, where Northamptonshire young people are placed in other authority areas, are managed on a case by case basis rather than there being a unified approach.
- 4.6 We are told that the county has a significant number of unaccompanied asylum seeking children. The IHAs we reviewed were basic and did not demonstrate that the clinicians undertaking these assessments have an understanding of the potential experiences of asylum seeking children. These are often highly likely to have long-term impact on emotional health and wellbeing. To date, clinicians have not received specialist training on this area and this is a gap. (**Recommendations 1.26, 2.25 and 3.15**)
- 4.7 Review health assessments are undertaken by the specialist health assessors, in a team established 18 months ago, and health visitors. The service aims to ensure continuity of health professional for young people where possible over their looked-after journey. Generally RHAs are good quality. Although better than in the IHAs we saw, evidence of the voice of the child varies; but we have seen some good practice, with a sense of the child as an individual and their personality. It was clear that practitioners give time to the young person, building a positive relationship when they may be meeting them for the first time. Some RHAs were episodic in nature and did not link clearly to previous assessments which could be addressed through the provision of effective quality assurance. There was evidence that some health needs are generally followed up promptly, such as immunisations.
- 4.8 Health assessors are highly creative in engaging young people and we were told that the number of young people who decline an assessment of their health is low.

Case example; *One looked after young person who was reluctant to engage with their review health assessment was seen in their bedroom as they did not want to get out of bed. They engaged well with the health assessor and the review health assessment was undertaken in part.*

Case example; *A young person had agreed to attend their review health assessment but when they came to the appointment, they refused to get out of the car in the car park. The health assessor joined the young person in the car and with the young person's agreement was able to undertake a partial health review.*

- 4.9 Young people, where age appropriate and competent, are being asked routinely to give their own consent. This encourages them to engage in managing their own health and wellbeing and is positive practice.
- 4.10 When scanned into the IT system, the health plan page becomes landscape making it difficult to access unless printed. As these are now sent electronically to GPs, it is not clear whether this may reduce GPs access and response to plans.
- 4.11 More work is needed to ensure that health plans from both IHAs and RHAs are SMART. Those we saw were largely lists of tasks rather than plans, lacking measurable health objectives, precise timescales and clear professional accountabilities. A number were of inadequate quality. **(Recommendations to 1.27, 2.26 and 3.16)**
- 4.12 Where GPs are using SystemOne, their information can be used to inform IHAs and RHAs. Information from GPs more widely is less routinely collected and the assessments for young people registered with these GPs may not be as well informed. CAMHS are not routinely contributing to IHAs or RHAs. There is a greater level of CAMHS engagement with statutory looked-after child reviews with practitioners telling us that they are routinely invited to these and that they attend these where they have significant involvement with a child and as capacity allows. If they are unable to attend, they submit a report or update to the review but these are not copied to the children looked-after health team. **(Recommendations 3.17 and 4.3)**
- 4.13 We did not see evidence of strengths and difficulties questionnaires (SDQs) being used to inform RHAs. Health visitors only receive the SDQ score and it is not clear how useful this is in individual RHAs and in evaluating emotional changes and development over time. Opportunities to engage young people in evaluating their own emotional growth through their annual health reviews are being lost. **(Recommendation 3.18)**

- 4.14 There is no formal agreement that a child looked after or care leaver will be supported by the vulnerable women's midwifery teams at NGH. Instead this relies on the community midwife referring to the team. Research shows that outcomes for this vulnerable cohort of young people are worse than their peers and this is a missed opportunity to provide enhanced support. **(Recommendations 1.28, 2.27 and 3.18)**
- 4.15 The health offer to care leavers remains under-developed and as this was an area for development identified in the 2011 SLAC inspection and attracting a recommendation at that time, this is a priority area for development. **(Recommendation 3.20)**
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Management

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

5.1 Leadership and management

- 5.1.1 Overall, partnerships are developing positively; not least through the development of an increasingly effective MASH and RISE, the sexual exploitation team. It also reflects well on health and social care that the acute trust electronic flagging systems are populated on a monthly basis on information received from NCC. These include looked-after children and children on CIN and child protection plans as well as those young people known to be at risk of or victims of CSE. This ensures staff at the EDs or other wards are aware of additional needs and concerns about a child or young person. However, we saw that barriers to communication and information sharing between children's social care and health services still exist, as they do between different health disciplines. This remains a challenge in the county.
- 5.1.2 The separation of the designated doctor role into separate portfolios for safeguarding and children looked-after facilitates the drive for improvement across safeguarding and children looked-after. The new designated doctor for looked-after children has a clear vision for the service and is keen to see sustainable progress. Notifications from children's social care are coming through more promptly. Health's governance arrangements have been strengthened and there is evidence of a whole system approach beginning to be developed but this is not yet embedded and there is more to do. **(Recommendation 5.2)**

- 5.1.3 The role of the designated nurse does not have the high profile as a safeguarding leader across services that we have seen elsewhere. Northamptonshire continues to have a significant and ongoing improvement agenda for safeguarding and the effective provision of health support for looked-after children. Given this, the need to support the work of the Improvement Board and increasingly complex local demographic factors, it is not clear that the designated nurse role has sufficient capacity to adequately address safeguarding and looked-after children in a combined portfolio. The CCG has invested in a full time Head of Nursing role whose portfolio is solely safeguarding and supports the designated function and increases capacity of CCG safeguarding provision. However, a review of the designated nurse role would be timely. (**Recommendation 5.3**)
- 5.1.4 Similarly, capacity for the safeguarding teams in provider services are stretched and are certainly contributing factors to some of the areas for development we have identified. In KGHT, the named midwife is employed full time in the role, however, her capacity is compromised by the excessive need for her to work clinical shifts because of shortages in hospital midwifery. She is assisted in the role by a community midwife who works as part of a rotation, however, this support is also reduced by the community midwife's current commitment to a course of study. At NGHT midwifery service, while the central team which works at the highest level of vulnerability and risk access monthly supervision, this is not being used effectively at present to raise the quality of safeguarding practice and recording in the team. We saw evidence of the small safeguarding midwifery team (1.5WTE) supporting ward midwives well in individual cases and attending discharge planning meetings to ensure new borns' needs were met. In some cases, they were identifying vulnerabilities on the ward that had not been recorded/assessed in the antenatal period. This strongly suggests, along with our concerns about the quality of practice in the central team, that increased levels of direct monitoring, training and supervision of midwives, including the central team are warranted. A member of the safeguarding midwifery team retired last year and has not been replaced, reducing the team's capacity further. (**Recommendation 1.29, 2.28 and 3.21**)
- 5.1.5 Significant investment in school nursing by public health and the increase of health resource into the MASH and RISE are noted and are commendable. These are likely to strengthen arrangements for early help and child protection.
- 5.1.6 The dynamic and enthusiastic leadership of the named GP is highly valued. He has a strong and commendable approach to developing county wide standardised tools for level 3 GP training, safeguarding recording templates and primary care's contribution to child protection conferences. This sits alongside his stringent monitoring and oversight of child protection report submission, action plans following SCRs and annual monitoring of safeguarding awareness in practices. He is clearly an asset in improving GP safeguarding practice.

- 5.1.7 We sampled a case where an infant with a genetic disorder was waiting for a swallowing assessment by a speech and language therapist (SALT) which was slow in taking place, leaving the infant fitted with a nasogastric tube which was likely to be detrimental to the child if prolonged. The baby was transferred to a hospital in a neighbouring authority for ongoing treatment. We identified that the current provision for SALT was insufficient to ensure effective cover as the specialist SALT was on long term sick leave. We were told that there is a specialist SALT therapist commissioned by NGH to provide 3 days a week ward work, child development centre assessments and out-patient clinics. There is no such commissioning arrangement in place for KGH. However, the CCG acknowledged that this should not have prevented the specialist assessment from taking place as the video-fluoroscopy service is provided irrespective of the SALT input.
(Recommendation 1.30, 2.29 and 3.22)
- 5.1.8 CAMHS was identified as an area of difficulty by commissioners prior to the CQC inspection in Feb 2015 and a decision was made to go to retender for the service. This has been deferred, however, and a draft specification given to NHFT CAMHS to deliver a single point of access (SPA) and an Integrated children's service to incorporate all the specialist children's health services other than the universal service (Health visitors and school nurses). The SPA is the referral management centre (RMC).
- 5.1.9 NHFT's transformation of service into an integrated children's service is underway. Services are being remodelled and through the process some staff have left the service. At the point of CQC Inspection in February, the service was operating at 65% of capacity. Although recruitment is underway to fill vacant posts, capacity pressures are significant. We saw evidence of the impact of this on the service's ability to respond promptly to young people with mental health needs waiting for 1:1 intervention to commence following assessment as well as urgent cases coming through the MASH.
(Recommendations 3.23)
- 5.1.10 For looked-after children, the provision of a specialist team of health assessors from a range of backgrounds, is a positive development and the health arrangements for looked-after children have improved as a result. The Being Healthy sub-group of the LSCB recognises the areas for development in the service and monitoring arrangements are improving. Some of these were identified in the previous joint inspection in 2011 and progress has been slow, particularly in the development of the health offer to care leavers, which remains under developed. Organisational changes and a hiatus in the team manager role have inhibited progress and some actions have slipped from amber to red on the trust's action plan, but the recent appointment of a new designated doctor and co-location arrangements is helping to move the service forward. To date the service has not used published reports from this CLAS review programme to help drive improvements and this is a missed opportunity.

- 5.1.11 The KGHFT named midwife is on the local CSE task group launching a new strategy for Northamptonshire. She also attends the CSE operational group where vulnerable children are discussed. She is a member of MARAC and also has access to the MARAC database. We saw case examples how this had been useful in identifying perpetrators who had moved on to new families.
- 5.1.12 Learning from local serious case reviews was evident and we heard about, and saw evidence of, a number of examples. For example, the ED at KGHFT now contact maternity services to check for any ante natal concerns for any baby under 28 days who attends the unit. This has positively identified babies who needed safeguarding.
- 5.1.13 Northamptonshire worked closely with a local university to develop an enhanced assessment of risk that would start in pregnancy and continue into early years. This work had been endorsed by the Children and Young People's Partnership but recently progress has stalled.
- 5.1.14 Safeguarding information sharing arrangements within NGH are robust with the trust named nurse and safeguarding team having a visible walk the floor presence, particularly in ED and the Paediatric wards. This facilitates discussion around complex cases.
- 5.1.15 The NGH Trust head of safeguarding reviews the top 10 attenders at ED every quarter and compares this with top attenders at KGH to identify any cases of concerns. This is good practice and was instigated by the Health Strategic Forum. Close working relationships between the named nurses at NGH and KGH ensures good practice is shared across the county with exchange of resources and expertise.
- 5.1.16 Due to separate information systems across agencies, it is not easy to ensure effective information exchange about children who may be attending other acute care settings across the county. There is a cross county information sharing protocol in place and adhered to by KGH and enhanced by rotation into MARSH to further develop working relationships. However, there is some way to go to establish a countywide culture of effective information exchange which is fully embraced by all partners at all levels and that is fully in line with both the letter and spirit of the multi-agency information sharing protocol and partner agencies' own guidance.
(Recommendations 1.31, 2.30 and 3.24) This issue has been drawn to the attention of Northamptonshire County Council.
- 5.1.17 The multi-agency FGM policy is in development. Given the high number of cases involving FGM issues locally, expediting its completion and introduction is advisable. This will facilitate provider trusts and other agencies in ensuring their own policies and practice fully reflect best practice to protect children at risk and women who are victims.

- 5.1.18 We were told about a big mental health forum last year where commissioners and providers met to discuss and agree a perinatal mental health pathway, including agreeing a training package, however this has not progressed.
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5.2 Governance

- 5.2.1 The Healthier Northamptonshire strategy is now aligned with the strategies of Nene and Corby CCGs and Northamptonshire County Council Health and Wellbeing Board, focus areas relating to children include increasing rates of breastfeeding and reducing childhood obesity levels.
- 5.2.2 There are good processes in place to ensure the quality of referrals made to children's social care and MASH by practitioners in the health providers. There has been significant work done to drive improvement in this area which has been an area for development in the past and efforts were strongly evidenced to have resulted in consistent good practice in this aspect of safeguarding in health. We were told MASH outcomes can be difficult to obtain however, and the NGHT named nurse holds a MASH referral follow up check monthly, if outcomes have not been received following referrals by trust practitioners.
- 5.2.3 All KGHFT midwives now have laptops and case note recording is live which means that any midwife working with an expectant woman is able to access the most up to date information. However, this change to an IT record means that some women have a combination of paper notes and an electronic record and neither is a complete record. This is creating risk that key information may be missed. (**Recommendation 2.31**)
- 5.2.4 There is no mechanism used consistently to alert named and safeguarding midwives and other health professionals of additional needs and vulnerabilities in expectant mothers. This deficit has developed since vulnerability form/cause for concern forms (previously SG2 forms) were abolished and not replaced. We were told that this was as a result of a recommendation made in the joint Ofsted/CQC safeguarding and looked-after children (SLAC) inspection of 2011. No such specific recommendation was made and this misunderstanding has resulted in a weaker approach to risk assessment in midwifery which is now inconsistent and inadequate. (**Refer to recommendations 1.1 and 2.1**)

- 5.2.5 We were told that KGHFT had not audited compliance with the NICE guidance on vulnerable pregnancies because of the use of a paper held record. This means that the trust cannot assure itself that it meets the recommendations and that all vulnerable women are receiving an enhanced service. With the move to an electronic recording system, it is to be expected that the trust will undertake an audit to assure NICE guidance compliance at the earliest opportunity. (**Recommendation 2.32**)
- 5.2.6 The absence of chronologies on families where there are child protection or child in need plans in place and the lack of reports and child protection conference minutes on patient records which we saw in a number of services, is unsafe. In files seen in midwifery, we were unable to find out the content of discussion and contribution of midwives to child protection conference. Midwives either complete reports for conference or attend. By not completing reports for conference, this means that they are not sharing the information with families. As minutes of conference are not stored on the record, then there is no reference or check made that the midwifery contribution is accurate. Record keeping and documentation in the health visitor service is also inconsistent. (**Reference to Recommendation 3.6**)
- 5.2.7 KGHFTs safeguarding committee has a programme of audits to monitor safeguarding practice across the trust. Results demonstrate improvement in those areas that are regularly audited. A recent audit on dog bites has resulted in improved paperwork, better informed families on the need to protect children from family dogs and reduced repeat ED attendances. Audits on a number of aspects of service are in place within NGHT, however outcomes and action plans are not used effectively to ensure safeguarding risks and additional needs are documented and that practice changes are embedded.
- 5.2.8 Across all services, operational governance and practice performance oversight at the frontline is not robust and there is an over-reliance on periodic, rather than regular audit, and robust operational practice monitoring to drive improvement. This has not been fully effective in ensuring embedded and sustained improvement in operational practice. For example, despite the ongoing development of standard operating procedures across the health visiting service, there is some way to go to ensure all teams are working in a standardised uniform way, to ensure equity of access and support across the county to all families. Cases sampled highlighted significant variation in DNA follow ups, access to antenatal visits (currently only 25% being achieved) and also in supervision arrangements for staff in different areas of the county. This underdevelopment of effective operational governance arrangements to ensure best practice is consistently delivered at the frontline was evidenced in all providers. (**Recommendations 1.32, 2.33 and 3.25**)

- 5.2.9 At KGH, a new approach to paediatric liaison was proving effective in identifying where children and young people attending ED may require additional support. A new paediatric liaison nurse had been appointed and was working hard to establish good safeguarding and child protection practice; screening all attendances of children and young people to ED. The paediatric liaison ensures that liaison forms for children identified as needing additional advice and support are copied to the health visitor or school nurse. A recent improvement is that the liaison form is now electronically copied to the GP to ensure that they are quickly informed of the reason for the attendance and request for intervention. At NGH, the senior safeguarding nurse review of all under 18 presentations seen in paediatric ED is an effective backstop to ensure any safeguarding issues are picked up. The monthly ED safeguarding meeting between named nurse, ED consultant, paediatric ward sister and head of emergency nurse practitioners provides a platform for case discussion and themed analysis of safeguarding cases that month.
- 5.2.10 A bi-monthly interface meeting at KGHFT ED and the monthly safeguarding meeting at NGH ED, facilitates continuous practice improvement. Opportunities to develop multi-agency engagement in these or similar forums which would facilitate effective information sharing and the engagement of vulnerable children and families into early help support, have not been explored in either acute trust, with NHFT or with children's social care. Where we have seen these forums developed to include social care on a routine and regular basis elsewhere, practitioners involved have been very positive about how this has enhanced information sharing and engaged vulnerable children and families with support at the earliest possible stage.
- 5.2.11 Safeguarding governance arrangements for the IC24 service at NGHT were unclear however at the time of this review. Where the named nurse at NGHT had identified sub-optimal safeguarding practice in IC24, she had been unable to address this effectively as, although situated at the acute trust, the service did not come under the acute trust's safeguarding governance. We were told that the governance arrangements for IC24 were through the emergency and out of hours team, monitored by the trust's quality assurance team. However, although the service had been commissioned by the CCG, the service was operating outside the governance arrangements overseen by the designated nurse who had little awareness of the service. On raising our concerns about the robustness of current arrangements, we were told that the tender process was underway for the provision of the IC24 service and that the issues around governance would be addressed as part of the commissioning specification.
(Recommendation 1.33)
- 5.2.12 In KGHFT, FGM is part of the domestic abuse policy and is a mandatory field on the new Medway maternity IT system. This is a positive inclusion, keeping this issue at the forefront of practitioners' thinking. To date, only one case has been identified and reported on.

5.3 Training and supervision

- 5.3.1 At Northampton General, paediatric ward staff have received some mental health training from CAMHS in conjunction with the trust's named nurse, although this is not recent. Paediatric ward staff at Kettering General have not had specific mental health training. In areas where there are significant numbers of young people with mental health crisis admitted to paediatric care, while appropriate treatment placements are sought or home support is put in place, it is essential that paediatric ward staff receive regular training in mental health to equip them in caring for this highly vulnerable cohort. **(Recommendation 1.34, 2.34 and 3.26)**
- 5.3.2 KGHFT current training needs analysis does not identify all those practitioners who require Level 3, including support staff in midwifery. This means that the trust's reported figure of 62% compliance is likely to be optimistic. The named nurse assured us that each business unit has a recovery plan in place. However, providing bespoke Level 3 training to midwives, means that this staff group are not benefitting from multi-agency, multi-professional input and shared learning. Therefore, the current offer does not meet the recommendations of the intercollegiate guidance. At NGHT, at the time of the last CQC hospital inspection in January 2014, NGH staff compliance with safeguarding training at Level 1 was 97%, Level 2 87% and Level 3 72%. The trust target for safeguarding training for Level 3 is 85% and there was an action plan in place for staff to access up to date level 3 training as more dates had been allocated. However, at NGH, level 3 safeguarding training is also in house, single agency training, and while staff are advised to attend LSCB multi-agency training, attendance is not centrally monitored. We noted the positive recent developments in bespoke training and competence monitoring through annual staff professional development reviews (PDRs) at NGHT.
- 5.3.3 In KGHFT, Level 3 training is currently available to qualified midwives and not to health care assistants. This does not meet the criteria within the intercollegiate guidance. Currently level 3 training is provided over 3 years and is for a total of 8 hours. It is bespoke training to midwives. We were told that there was no capacity within the trust's generic Level 3 training to ensure all midwives were trained. This is not acceptable. **(Recommendation to 1.35 and 2.35)**

- 5.3.4 Supervision in child protection and safeguarding practice across the health economy is underdeveloped and is an area for development across services, including adult services. Most practitioners are accessing group or ad-hoc supervision and this is not always sufficient to ensure practitioners and supervisory staff are well equipped and supported in their roles. An example being; in KGHFT, only the vulnerable team of midwives receive group supervision, there is no one to one supervision available to other midwives. Named nurses in trusts and named midwives are not receiving routine individual supervision from the designated nurse in line with guidance, although the named professional forum is well established, providing valuable peer support and an element of group supervision. While we saw examples of where discussion of a case in supervision was recorded on the client record in CAMHS in line with best practice, this was not routine practice for all CAMHS staff. **(Recommendations 1.36, 2.36 and 3.27) This issue has been drawn to the attention of Northamptonshire County Council.**
- 5.3.5 The preceptorship of new midwives in KGHFT does not currently require them to demonstrate competency in child protection and safeguarding; instead there is an over reliance on attending training. **(Recommendation 2.37)**

Recommendations

- 1. Nene CCG and Northampton General Hospital NHS Trust should:**
 - 1.1 Ensure the implementation of a standardised risk assessment proforma with prompts and trigger questions to promote practitioners' consideration of all potential social vulnerabilities and risks, repeated as appropriate during pregnancy
 - 1.2 Ensure that midwives routinely see mothers-to-be alone to give them the opportunity to disclose any risks or issues which are likely to impact on the health and wellbeing of mother and unborn baby
 - 1.3 Ensure that midwives routinely ascertain and record paternal details as part of their risk assessment
 - 1.4 Ensure that midwives take steps to co-ordinate appointments with appointments in other hospital departments for women where vulnerabilities have been identified to reduce risks of non-attendance
 - 1.5 Ensure that when children and young people under 18 present at the emergency department that their parents, next of kin and details of an accompanying adult are recorded
 - 1.6 Ensure that there is separate ED paediatric documentation incorporating an effective child safeguarding triage section, taking into account previous attendances, and subject to robust operational governance to ensure completion in line with best practice
 - 1.7 Explore the establishment of multi-agency psycho-social forums in the midwifery services to discuss vulnerable pregnancies and thereby facilitate access into early help provision
 - 1.8 Ensure that midwives routinely complete health visitor liaison forms as appropriate; send these promptly to the relevant health visiting service and retain copies on maternity records
 - 1.9 Ensure that where vulnerabilities are identified in midwifery, that women are supported by timely home visits as part of a robust care planning process, subject to effective operational governance
 - 1.10 Review the provision of specialist midwifery roles to ensure that the needs of expectant mothers, including teenagers, with identified higher levels of vulnerability are met appropriately

- 1.11 Ensure that common assessment frameworks (CAFs) are outcome focused, with clear timescales and clear professional roles and responsibilities and that the benefits of CAF are actively promoted to expectant women and new mothers
- 1.12 Ensure that systems and processes are put in place so that emergency department practitioners demonstrate awareness of the risks of hidden harm to children, underpinned by Think Family principles and service model, and subject to effective governance arrangements
- 1.13 Work with Public Health, Northamptonshire County Council, to ensure that the paediatric liaison notification pathway from the ED to school nurses operates effectively
- 1.14 Work with CAN substance misuse service to ensure a robust care pathway is established to engage young people with substance misuse issues with appropriate support in a timely way
- 1.15 Ensure that the self-harm integrated notes documentation is completed in appropriate cases and advice and guidance sections routinely shared with parents and young people
- 1.16 Ensure that robust individual support protocols, that include consideration of environmental risks, are in place for each child admitted to paediatric wards in mental health crisis
- 1.17 Ensure a robust approach to SMART care planning is in place in the midwifery service
- 1.18 Ensure that practitioners make effective use of chronologies and genograms to inform their practice with vulnerable children and families
- 1.19 Ensure robust records management and quality monitoring arrangements are in place in order that client records are accurate and comprehensive; inclusive of all pertinent documentation and a complete record of all practitioner activity
- 1.20 Ensure that birth plans are routinely shared with expectant mothers in order that the woman is fully engaged with the planning of her care during labour and in the post natal period
- 1.21 Ensure that women and young people who are victims or at risk of FGM have good access to specialist support and that staff and clinicians across services are well informed and knowledgeable
- 1.22 Ensure effective direct liaison and information sharing, including sharing of relapse indicators and contingency plans, with other disciplines is established as routine practice in cases where there are known to be vulnerable children

- 1.23 Ensure that an effective quality assurance framework is put in place to monitor and improve the quality of initial and review health assessments, including ensuring a strong reflection of the voice and individuality of the young person
- 1.24 Work with Northamptonshire County Council to ensure that looked-after children's birth and parental health history is recorded when the child first becomes looked-after and follows the young person's journey through health as a looked after child
- 1.25 Ensure that young people ethnicity, language and religion is recorded clearly in order that healthcare can be provided in the most appropriate way
- 1.26 Ensure that health practitioners involved in initial and review health assessments for unaccompanied asylum seeking children, have a good understanding of the issues likely to effect the health and wellbeing of these young people and that they have undertaken appropriate training
- 1.27 Ensure that health plans developed from initial and review health assessments are SMART; outcome focused and measurable, with clear timescales and professional accountabilities
- 1.28 Ensure that looked after young people or care leavers who become pregnant receive appropriate enhanced support from midwifery services
- 1.29 Ensure there is sufficient capacity in safeguarding teams to provide effective leadership, supervision and governance to facilitate continuous operational improvement in safeguarding practice
- 1.30 Ensure there is sufficient specialist speech and language therapy provision across Northamptonshire in accordance with statutory guidance
- 1.31 Work with Northamptonshire County Council to improve the effectiveness of information exchange between agencies in line with the multi-agency information sharing protocol and partner agencies' own guidance, subject to robust operational monitoring arrangements in order that this becomes routine and embedded practice
- 1.32 Ensure that robust operational safeguarding governance arrangements are in place to monitor frontline practitioner compliance with best safeguarding practice and trust expectations
- 1.33 Work with IC24 to ensure that robust and effective safeguarding governance arrangements are in place at IC24
- 1.34 Ensure that a programme of appropriate mental health training is put in place to support paediatric staff in caring for young people with mental health issues

- 1.35 Ensure that workforce training needs analyses correctly identifies safeguarding training needs according to competency required for roles and responsibilities and contact with children, rather than job level and that multi-agency training uptake is compliant with *Working Together To Safeguard Children 2013* and intercollegiate guidance
 - 1.36 Ensure that robust safeguarding supervision arrangements are put in place for all named professionals and frontline practitioners in line with *Working Together to Safeguard Children 2013*
- 2. Nene CCG, Corby CCG and Kettering General Hospital NHS Trust should:**
- 2.1 Ensure the implementation of a standardised risk assessment proforma with prompts and trigger questions to promote practitioners' consideration of all potential social vulnerabilities and risks, repeated as appropriate during pregnancy
 - 2.2 Ensure that midwives routinely see mothers-to-be alone to give them the opportunity to disclose any risks or issues which are likely to impact on the health and wellbeing of mother and unborn baby
 - 2.3 Ensure that midwives take steps to co-ordinate appointments with appointments in other hospital departments for women where vulnerabilities have been identified to reduce risks of non-attendance
 - 2.4 Ensure that the children's waiting area in the emergency department is observable by staff at all times
 - 2.5 Ensure that when children and young people under 18 present at the emergency department that their parents, next of kin and details of an accompanying adult are recorded
 - 2.6 Ensure that there is separate ED paediatric documentation incorporating an effective child safeguarding triage section, taking into account previous attendances, and subject to robust operational governance to ensure completion in line with best practice
 - 2.7 Ensure that an effective head injury protocol in line with national guidance and the LSCB protocol is put in place in the emergency department
 - 2.8 Explore the establishment of multi-agency psycho-social forums in the midwifery services to discuss vulnerable pregnancies and thereby facilitate access into early help provision
 - 2.9 Review the provision of specialist midwifery roles to ensure that the needs of expectant mothers, including teenagers, with identified higher levels of vulnerability are met appropriately

- 2.10 Ensure that common assessment frameworks (CAFs) are outcome focused, with clear timescales and clear professional roles and responsibilities and that the benefits of CAF are active promoted to expectant women and new mothers
- 2.11 Ensure a robust approach to assessment, care planning and regular care plan review is put in place across all services: where child protection plans are in place, a child's care plan should link to the over-arching care plan
- 2.12 Ensure that systems and processes are put in place so that emergency department practitioners demonstrate awareness of the risks of hidden harm to children, underpinned by Think Family principles and service model, and subject to effective governance arrangements
- 2.13 Work with CAN substance misuse service to ensure a robust care pathway is established to engage young people with substance misuse issues with appropriate support in a timely way
- 2.14 Ensure that the self-harm integrated notes documentation is completed in appropriate cases and advice and guidance sections routinely shared with parents and young people
- 2.15 Ensure that robust individual support protocols, that include consideration of environmental risks, are in place for each child admitted to paediatric wards in mental health crisis
- 2.16 Ensure a robust approach to SMART care planning is in place in the midwifery service
- 2.17 Ensure that practitioners make effective use of chronologies and genograms to inform their practice with vulnerable children and families
- 2.18 Ensure robust records management and quality monitoring arrangements are in place in order that client records are accurate and comprehensive; inclusive of all pertinent documentation and a complete record of all practitioner activity
- 2.19 Ensure that birth plans are routinely shared with expectant mothers in order that the woman is fully engaged with the planning of her care during labour and in the post natal period
- 2.20 Ensure that women and young people who are victims or at risk of FGM have good access to specialist support and that staff and clinicians across services are well informed and knowledgeable
- 2.21 Ensure effective direct liaison and information sharing with other disciplines, including sharing of relapse indicators and contingency plans, is established as routine practice in cases where there are known to be vulnerable children

- 2.22 Put in place a policy and protocol for children at risk of absconding or going missing to accord with the LSCB multi-agency protocol
- 2.23 Work with Northamptonshire County Council to ensure that looked-after children's birth and parental health history is recorded when the child first becomes looked-after and follows the young person's journey through health as a looked after child
- 2.24 Ensure that young people ethnicity, language and religion is recorded clearly in order that healthcare can be provided in the most appropriate way
- 2.25 Ensure that health practitioners involved in initial and review health assessments for unaccompanied asylum seeking children, have a good understanding of the issues likely to effect the health and wellbeing of these young people and that they have undertaken appropriate training
- 2.26 Ensure that health plans developed from initial and review health assessments are SMART; outcome focused and measurable, with clear timescales and professional accountabilities
- 2.27 Ensure that looked after young people or care leavers who become pregnant receive appropriate enhanced support from midwifery services
- 2.28 Ensure there is sufficient capacity in safeguarding teams to provide effective leadership, supervision and governance to facilitate continuous operational improvement in safeguarding practice
- 2.29 Ensure there is sufficient specialist speech and language therapy provision across Northamptonshire in accordance with statutory guidance
- 2.30 Work with Northamptonshire County Council to improve the effectiveness of information exchange between agencies in line with the multi-agency information sharing protocol and partner agencies' own guidance, subject to robust operational monitoring arrangements in order that this becomes routine and embedded practice
- 2.31 Ensure that the transfer from paper to electronic records in the midwifery service is expedited to provide a single maternal case record holding all key information
- 2.32 Ensure that an audit to assess compliance with NICE guidance on vulnerable pregnancies is undertaken and appropriate actions taken to ensure any deficits are addressed
- 2.33 Ensure that robust operational safeguarding governance arrangements are in place to monitor frontline practitioner compliance with best safeguarding practice and trust expectations

- 2.34 Ensure that a programme of appropriate mental health training is put in place to support paediatric staff in caring for young people with mental health issues
 - 2.35 Ensure that workforce training needs analyses correctly identifies safeguarding training needs according to competency required for roles and responsibilities and contact with children, rather than job level and that multi-agency training uptake is compliant with *Working Together To Safeguard Children 2013* and intercollegiate guidance
 - 2.36 Ensure that robust safeguarding supervision arrangements are put in place for all named professionals and frontline practitioners in line with *Working Together to Safeguard Children 2013*
 - 2.37 Ensure that the preceptorship programme for midwives is competency based to ensure best practice is embedded
- 3. Nene CCG, Corby CCG and Northamptonshire Healthcare NHS Foundation Trust should:**
- 3.1 Ensure that common assessment frameworks (CAFs) are outcome focused, with clear timescales and clear professional roles and responsibilities and that the benefits of CAF are active promoted to expectant women and new mothers
 - 3.2 Ensure a robust approach to assessment, care planning and regular care plan review is put in place across all services: where child protection plans are in place, a child's care plan should link to the over-arching care plan
 - 3.3 Develop and commission an effective specialist perinatal care pathway to support women with perinatal mental health concerns and ensuring equitable access to support countywide
 - 3.4 Work with the acute trusts to ensure that the paediatric liaison notification pathway from the emergency department to school nurses operates effectively
 - 3.5 Ensure that robust individual support protocols, that include consideration of environmental risks, are in place for each child admitted to paediatric wards in mental health crisis
 - 3.6 Ensure that practitioners make effective use of chronologies and genograms to inform their practice with vulnerable children and families
 - 3.7 Ensure effective direct liaison and information sharing with other disciplines, including sharing of relapse indicators and contingency plans, is established as routine practice in cases where there are known to be vulnerable children

- 3.8 Revise the adult mental health service's DNA policy and protocol to ensure that practitioners are prompted to consider child safeguarding issues for children known to be at risk in the event of an adult's non-attendance
- 3.9 Ensure that details of children of adult mental health service users are included in the client details on the case record and that appropriate flags are in place to alert practitioners and managers to clients with children who are subject to CIN and child protection plans
- 3.10 Ensure that the mental health service model, systems and processes accords with an effective Think Family model of service delivery, prioritising the safeguarding of children while working primarily with the adult
- 3.11 Ensure that robust records management and quality monitoring arrangements are in place in order that client records are accurate and comprehensive; inclusive of all pertinent documentation and a complete record of all practitioner activity
- 3.12 Ensure that an effective quality assurance framework is put in place to monitor and improve the quality of initial and review health assessments, including ensuring a strong reflection of the voice and individuality of the young person
- 3.13 Work with Northamptonshire County Council to ensure that looked-after children's birth and parental health history is recorded when the child first becomes looked-after and follows the young person's journey through health as a looked after child
- 3.14 Ensure that young people ethnicity, language and religion is recorded clearly in order that healthcare can be provided in the most appropriate way
- 3.15 Ensure that health practitioners involved in initial and review health assessments for unaccompanied asylum seeking children, have a good understanding of the issues likely to effect the health and wellbeing of these young people and that they have undertaken appropriate training
- 3.16 Ensure that health plans developed from initial and review health assessments are SMART; outcome focused and measurable, with clear timescales and professional accountabilities
- 3.17 Ensure that CAMHs contribute to initial and review health assessments as appropriate in order that all the young person's health and wellbeing issues inform looked-after child assessments
- 3.18 Ensure that strengths and difficulties questionnaires are used effectively to inform review health assessments and that looked-after young people are given the opportunity to use the SDQ to track their personal emotional health journey

- 3.19 Ensure that looked after young people or care leavers who become pregnant receive appropriate enhanced support from midwifery services
 - 3.20 Ensure that care leavers are well supported by health as they enter adulthood; to include health histories/passports and age appropriate information personalised to the young person's needs and lifestyle
 - 3.21 Ensure there is sufficient capacity in safeguarding teams to provide effective leadership, supervision and governance to facilitate continuous operational improvement in safeguarding practice
 - 3.22 Ensure there is sufficient specialist speech and language therapy provision across Northamptonshire in accordance with statutory guidance
 - 3.23 Ensure young people experiencing mental health difficulties are able to receive appropriate intervention promptly following assessment of their emotional health
 - 3.24 Work with Northamptonshire County Council to improve the effectiveness of information exchange between agencies in line with the multi-agency information sharing protocol and partner agencies' own guidance, subject to robust operational monitoring arrangements in order that this becomes routine and embedded practice
 - 3.25 Ensure that robust operational safeguarding governance arrangements are in place to monitor frontline practitioner compliance with best safeguarding practice and trust expectations
 - 3.26 Ensure that a programme of appropriate mental health training is put in place to support paediatric staff in caring for young people with mental health issues
 - 3.27 Ensure that robust safeguarding supervision arrangements are put in place for all named professionals and frontline practitioners in line with Working Together to Safeguard Children 2013
- 4. NHS England, in partnership with Nene CCG and Corby CCG should;**
- 4.1 Work with General Practitioners to ensure that vulnerable families liaison meetings are established across Northamptonshire primary care, involving other health disciplines such as health visitor, school nurse, midwifery, substance misuse, relevant to the particular general practice area
 - 4.2 Ensure that GPs and primary care services have a good understanding of and engagement with MARAC arrangements
 - 4.3 Ensure that GPs contribute to initial and review health assessments as appropriate in order that all the young person's health and wellbeing issues inform looked-after child assessments

5. Nene CCG and Corby CCG should;

- 5.1 Work with Northamptonshire County Council and the LSCB to ensure that a shared LCSB escalation policy is in place, well understood by practitioners and operating effectively
- 5.2 Work with Northamptonshire County Council to establish a robust whole system approach to the governance of the health of looked-after children and young people
- 5.3 Review the role of the designated nurse for safeguarding and looked-after children to ensure that there is sufficient leadership, supervision and governance capacity to drive and monitor progress in both safeguarding and looked-after children

Next steps

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

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