

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

Children Looked After and Safeguarding

The role of health services in Herefordshire

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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 Hereford. 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 Hereford, 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 2015.
- 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 89 children and young people.

Context of the review

Child and Maternal Health Observatory (ChiMat) data states that children and young people under the age of 20 years make up 21.5% of the population of County of Herefordshire with 8.8% of school age children being from a minority ethnic group.

On the whole, the health and wellbeing of children in County of Herefordshire is generally similar to the England average. Infant and child mortality rates are similar to the England average. Commissioning and planning of most health services for children are carried out by Herefordshire CCG in partnership with the children's wellbeing directorship, Herefordshire council.

The rate of looked after children, under age 18 per 10,000 children as at March 2014, was not significantly different to the England average. The overall percentage of all Herefordshire's children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was not significantly different when compared to the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2013/14 was significantly better than the England average.

In terms of hospital admissions; the rate of hospital admissions caused by injuries in children under 14 years of age was not significantly different to the England average conversely, the rate of hospital admissions caused by injuries in young people aged 15-24 was significantly better than the England average. With regards to mental health, the rate of hospital admissions for mental health conditions and the rate of hospital admissions as a result of self-harm in 2013/14 were not significantly different when compared to the England average.

Acute hospital services are provided by Wye Valley NHS Trust (WVNHST)

Community based services are provided by Wye Valley NHS Trust and 2gether NHS Foundation Trust (2GNHSFT)

Child and adolescent mental health services (CAMHS) are provided by 2gether NHS Foundation Trust

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

Community adolescent drugs services are commissioned and provided by the local authority

The last inspection of health services for Hereford's children took place in September 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review. At the time the 'overall effectiveness of the safeguarding services' outcome was assessed as adequate.

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

We heard from one young person we spoke with at the Hereford County Hospital emergency department who was attending for treatment. They told us:

“It’s much better here now than it was before. It’s quicker (regarding waiting times) and the children’s waiting room is good. Being brought straight in here was good too.” (the children’s dedicated triage and treatment cubicle).

We spoke with a ‘young ambassador’ representative during a meeting at Hereford County hospital. They told us:

“It’s been really good being a group member. We’ve been able to look at things here (County hospital) from a child’s perspective and what we say seems to be listened to. We’re really proud of how good the waiting area (for children and young people) is in accident and emergency now”.

We spoke with young people in care. When asked about their health assessments they told us:

“When they talk to the carers on the phone they should talk to us too so we know what to expect”.

Another told us:

“A letter was sent to the foster carer and not to me and I didn’t know anything about what was happening until there was a knock on the door”.

They went on to tell us:

“If letters are being sent to other people about my health then I should get a copy too – I get copies of everything else”.

Another young person told us:

“Give us more notice about medicals because sometimes we already have plans to do other things on that date”.

One young person we spoke with who had left care told us:

“When I was younger I didn’t really have anyone to talk to about my health but now I’m older it’s easier”.

We spoke with foster carers in Hereford. One told us:

“Health visitors are always available, easy to contact and always helpful. I’ve been doing this (foster caring) for a long time but even now I sometimes need a bit of help or advice. It’s always there for me when I need it”.

Another we spoke with told us:

“Some GPs could do with some training about the special needs and vulnerabilities of children in care. It’s like they don’t know about the extra risks around these kids. I don’t think looked after children get prioritised the way they should and in all honesty I can get a better service by taking them to the drop in centre. At least you get seen on the same day although in all honesty I don’t think they are all that aware of looked after kids. Dentists are great though. They are far more aware of looked after children and will always prioritise treatment for them once they know”.

When asked about her experience of GPs, another foster carer told us:

“I’ve been with the same GP for years and always take my kids there. He’s great and I never have a problem getting them seen”.

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 Children and young people who attend the emergency department (ED) at Hereford County Hospital are cared for in a safe, child centred environment which caters well for their specialist requirements. A small dedicated paediatric waiting area has been built with two children's triage and treatment cubicles. This is a significant improvement over previous arrangements and has benefited from the input of the paediatric young people's ambassador group. The ambassador group is a group of school age young people who are invited to voice their views regarding service provision at the hospital so that those services can be adapted, where possible, to better serve young people in the area.

1.2 Most children and young people who attend ED are being seen promptly. ED practitioners have recognised the ongoing need to ensure children and young people are prioritised, where clinically appropriate, and not kept waiting in the department for any longer than is necessary. To aid identification on the electronic patient list a special alert is now being used to provide a visual prompt to practitioners that the patient is a child. More robust arrangements are planned for introduction at the next IT revision.

1.3 During our visit to the ED we saw that details of children and young people attending the department are obtained by the ED receptionists and entered onto the IT system. This includes demographic details and also the names and status of any accompanying adult. Although we did not see details of any children's social workers being recorded at the time of booking we did note that electronic alerts are available on the system to inform practitioners of any additional information that they need to consider. There is clear guidance available to staff about how to share information on any child or young person who is looked after or has a child protection plan in place.

1.4 All children and young people who are admitted to the paediatric ward benefit from an assessment of their risk of harm or safeguarding requirements. For older children this also includes a brief risk assessment about depression and alcohol or substance misuse. This is good practice.

1.5 GPs receive a copy of the discharge summary for each child or young person who attends the ED. This is detailed and gives the GP sufficient information about the reason for the attendance and any subsequent treatment. This means that GPs are able to consider the full details of the ED attendance in the context of the child or young person's overall health needs.

1.6 Robust arrangements are in place to ensure that infants under one year old are only seen and discharged by senior clinicians. There is good access to consultant and senior paediatricians through the children's ward. The two departments work closely together and we saw how any child or young person, where there were any safeguarding concerns, could be transferred to the paediatric ward for further observation or admission for ongoing care.

1.7 In midwifery services, it is expected that women book their pregnancy at a GP surgery or at a children's centre unless arranged by exception. This policy does not support robust risk assessment as it does not routinely enable midwives to determine, for example, if a home visit with children's social care or a health visitor might be required in order to assess the home environment. We were unable to examine examples of quality risk assessments during our visit (see also 2.11 below, **(Recommendation 3.1)**)

1.8 Access to services for local Eastern European communities has been recognised as a barrier within midwifery services and as such WVNHS has employed a Slovakian/Lithuanian patient advice and liaison service (PALS) worker to support families to access appointments. Polish parent craft classes are also offered. These offers promote interaction with midwifery professionals.

1.9 Health is well represented at the multi-agency safeguarding hub (MASH), the single point of contact for any person in which to report any safeguarding concerns they might have. Referrals into the MASH are assessed in a timely fashion and either further referred for child protection consideration or signposted to other multi-disciplinary or multi-agency professionals. We were advised that when referrals of poor quality were received then the referrer would be advised to make another referral in more detail. This is considered good practice rather than designating the referrals for 'no further action'.

1.10 Health professionals within the MASH told us of difficulties they can have in obtaining information from individual health visitors in the county due to their use of paper records and also because they are based across nine geographical regions around the county. This also means that there is considerable duplication of record keeping rather than maintaining information on a single electronic record. Difficulties in obtaining information can also lead to delays in the decision making process. **(Recommendation 2.1)**

1.11 The school nursing service has undergone significant changes over the last year following concerns that the service had become untenable due to capacity issues and therefore not able to effectively manage the increasing numbers of children subject to child protection plans. The school nursing service undertook a detailed analysis of safeguarding cases on the caseload, to elicit the most appropriate health care provider for the individual child. The analysis highlighted some children received services from a number of health care professionals and did not require specific school nursing services. From this analysis a new referral criteria was launched in December 2014, to ensure that all children receive the required care from the most appropriate service. Since this time the school nursing caseload has significantly reduced and this has allowed them to deliver services to children requiring specific school nursing services.

School nurses we spoke with told us that they now feel more able to provide early intervention work to children and young people which in turn it is hoped will reduce the number of cases being referred for child protection measures. Instead of attending all case conferences routinely where they may not have any specific contribution to make, they have prioritised attendance where they know they have relevant input, and this has enabled them to undertake early intervention work in the time freed up. We saw that despite their not routinely attending child protection conferences they did receive minutes of all meetings and, from these, could still plan their own interventions accordingly and seek to contribute where relevant.

1.12 The health visitor interface with GPs is variable with some maintaining little contact with GPs and others sharing information well. We were told that in rural areas the interface is generally better which is attributable to fewer staff and good established working practices with local workers. In one area the practice manager always contacts health visitors to notify of DNAs, change of registration, house moves and to invite to practice meetings. This is good practice and supports information sharing. However, this is not a standard practice throughout the county which we were told has previously been escalated via the safeguarding team. **(Recommendation 2.2)**

1.13 Referrals into CAMHS are screened by the team manager and a child or young person should expect to receive their first choice appointment within four weeks of the referral being received. If CAMHS is agreed to be the appropriate service, then a partnership appointment should be offered within 12 weeks. Demand for the service is high and approximately 25% of the referrals are declined, with some being directly signposted to the local counselling service. This should minimise delay in the young person accessing help and support. However, target waiting times are not always being met and this was evidenced in some of the cases we reviewed. We are unaware of any audits being undertaken to assess the reliability of expected waiting times. **(Recommendation 1.1)**

In one case examined, we saw that a child who was being looked after by the local authority and who was at risk of self-harming due to their poor emotional health was referred to the service at the end of March 2015. An initial appointment had been made for the young person to be seen during May and this breached the trust's four-week-wait measure. Not only was that appointment cancelled by the trust but a further appointment had yet to be made by the time of our review in July 2015, despite the service being prompted by the child's foster carer after the initial appointment had been cancelled.

We had previously noted a lack of information regarding the young person's mental and emotional health on the child's LAC initial health assessment, an assessment that was itself over the four-week measure, although it was clear that the young person was due to be seen by CAMHS.

There was no record on either the LAC assessment record examined or the CAMHS record as to whether either of these services had spoken to each other about the young person's needs. We acknowledge that it was important to seek the child's consent to exchange information. However, the lack of communication between both services and the absence of a diligent follow-up process meant that this particular young person was left without the necessary support for an unacceptable period of over three months.

1.14 The CAMH service has become more responsive to fluctuations in referrals and recently introduced evening clinics to meet the demand of a high number of referrals in March. However, there is no additional resource to cope with this extra work and this is placing considerable stress on practitioners. (**Recommendation 2.2** as at 1.12 above)

1.15 Capacity and re commissioning of both the young person and adult substance services in drug and alcohol services Herefordshire (DASH) is impacting on the ability to undertake early intervention programmes and the young person's service is currently running with a waiting list for service provision. We are aware that the service is in the process of being re-commissioned with plans to provide an '11 plus' service from November 2015.

1.16 The integrated sexual health (ISH) team are information sharing and liaising well with all partners in the health and social care economy to ensure young people have their needs met on an ongoing basis. In cases examined we saw good levels of liaison between the team and other multi-agency and multi-disciplinary teams, including GPs, health visitors, midwifery and children's social care.

1.17 ISH report they have good relationships within WVNHSST for termination of pregnancy services, and are rearranging to co-locate with early abortion service to ensure future contraceptive needs are managed. Counselling support is available pre-termination and the commissioners are reported to be currently in discussion with Marie Stopes for the provision of post termination of pregnancy support.

1.18 Young people have open access to contraception and sexual health (CASH) services in Hereford in both generic and young person specific clinics from Monday to Friday. Emergency contraception is available seven days a week from selected pharmacists on a confidential basis. Annual valuation from service users has led to a change in the day young person clinics are provided to fit in with college sessions and thus facilitate attendance. Comments received from service users at the drop in clinics demonstrate a high level of satisfaction with the service.

1.19 Within CASH we saw that a comprehensive assessment tool is in place and used for all under 18's. There is thorough questioning and analysis of risks around child sexual exploitation (CSE) and coercive relationships, with onward referrals being made if considered appropriate and necessary. All cases sampled highlighted consistent identification and consideration of vulnerability.

In adult mental health we learned of a midwifery mental health clinic being run one afternoon every month, led by a consultant obstetrician from the acute trust and supported by a mental health trust practitioner. Parents were identified for this service via midwifery, health visitors and primary care. Whilst having a broader remit than a perinatal mental health clinic, this initiative provides support to women who might be experiencing mental ill health in pregnancy or after giving birth.

2. Children in need

2.1 In the Ross-on-Wye minor injury unit (MIU) visited we saw that there are no prompts on adult admission documentation to prompt staff to make enquiries about children and young people to which the adult might have access or for whom they have parental responsibility. There is an over reliance on individual's professional curiosity to ask those important questions and in documentation examined we saw little evidence of whether those questions had actually been asked. This means hidden children of adults who engage in risky behaviours might not be protected well. (**Recommendation 3.8**)

2.2 Attendance at MIU's and the Hereford County hospital ED by children and young people generate a standard letter of attendance which we were advised is sent only to the GP and to the safeguarding team. There is an expectation that the safeguarding team will identify the attendance and send out letters to the health visitor or school nurse as required. However, the system is not robust and there is no auditable trail from MIU to confirm actions taken by the safeguarding team or other department if referred on. (**Recommendation 3.2**)

2.3 Staff at Ross-on-Wye MIU are aware of escalation pathways to be followed in relation to concerns they might have about a child. A flow chart was seen on the office wall in the unit that detailed who to contact in the event of query, advice or referral onto the MASH. This was also true of the Ledbury MIU provided by Shaw Healthcare where we examined a case which demonstrated tenacity on the part of the nurse on duty to safeguard a young person with whom she had contact.

A young child had been brought to Ledbury MIU with a cigarette stub stuck to their nose. The nurse had examined the child and referred onto ENT at the local hospital.

However, it transpired that the child had not been taken to the hospital as arranged and therefore the nurse identified and contacted the child's health visitor who described other areas of concern. With this in mind the MIU nurse made a referral to the MASH using the required multi-agency referral form and copies of the documentation were placed on file and also sent to safeguarding team. A notification letter was also sent to GP.

2.4 In Ross-on-Wye MIU, some records examined demonstrated that children had not been routinely weighed before being prescribed medication and an estimation of their weight used in accordance with their age. However, we have since been advised that paracetamol and ibuprofen are the only drugs that children are prescribed and this is in line with current recommendations. (**Recommendation 3.3**)

2.5 Children and young people attending the ED and associated urgent care facilities do not benefit from any meaningful paediatric liaison. The current arrangements in place to share appropriately detailed information with other health professionals in a timely and accurate way are weak and do not safeguard children well. There has been no audit to test the effectiveness of the arrangements of the school nurses in the follow up of children and young people who attend the department following an incident of self-harm. Notifications of attendance at ED can often be delayed and notifications to inform of ED attendances examined demonstrated that they were not always sufficiently detailed or timely. (**Recommendation 3.2** as at 2.2 above)

2.6 All children and young people under 16 who attend the ED at the County hospital benefit from a safeguarding triage to establish if there are any safeguarding or child protection concerns. However, the current assessment does not sufficiently focus on the older young person and any risk taking behaviours or vulnerability that they might exhibit or undertake. WVNHSST recognise this and are exploring how best to capture this important information. (**Recommendation 3.4**)

2.7 Children and young people who attend the ED in mental health crises or following incidents of self-harm have their physical health stabilised and are then quickly transferred to the paediatric ward to await a child and adolescent mental health service (CAMHS) assessment. However, there is a limited, on call out of hours CAMH service available and this means that children and young people are facing unnecessary stays in a clinical environment with no specialist care planning whilst they wait, other than the support provided by agency psychiatric nurses. Hereford's young people do not have ready access to an out of hour's consultant CAMHS practitioner. (**Recommendation 5.2**)

2.8 The paediatric ward at County hospital has good arrangements in place to assess risk and plan for the physical care of young people in mental health crisis to ensure that they are protected from harming themselves and others. The CCG are supportive and fund agency specialist psychiatric nurses who are used to provide support and observe closely the young person whilst they are on the ward. However, we were advised that there has been no recent training provided to the paediatric ward staff on caring for children and young people with acute mental health and self-harming behaviours to better prepare them to be in a position to provide appropriate care and support if required to do so. We have since been advised however, that training was provided by a consultant psychiatrist and a specialist nurse in December 2014 for ED staff and in March 2015 to paediatric staff, with paediatricians being trained in April 2015. (**Recommendation 4.1**)

2.9 In midwifery, apart from cases that meet level four threshold (requiring the maximum amount of safeguarding support), there are no specialist midwives for vulnerabilities at lower levels. There is a gap in midwifery support arrangements for teenage pregnancy, mothers-to-be with mental health problems or who are misusing substances but who are not at child protection threshold. Vulnerable women who do meet child protection thresholds are usually seen in the 'safeguarding' clinic where their care is co-ordinated by the safeguarding midwife and a consultant with a special interest in safeguarding. All other vulnerabilities below child protection threshold are included in all core community midwifery models, and we saw variability in how, or even if, these vulnerabilities were identified and flagged to the safeguarding midwife. (**Recommendation 1.2**)

2.10 There are good joint working arrangements between midwifery, adult mental health and DASH teams within the county. Parents-to-be with higher level mental health and substance misuse issues are supported by safe and efficient services working in a cohesive manner. There are arrangements for some co-run antenatal clinics to allow parents to access midwifery and community psychiatric nurse services together to facilitate better engagement with services and there are formal pathways in place for joint working between midwifery, adult mental health and DASH. Commissioners are giving due consideration to improving the identification of need across midwifery.

2.11 Cases seen in midwifery services highlighted significant gaps in initial and ongoing risk assessment and identification and further analysis and exploration of vulnerabilities, particularly around domestic violence. Although domestic violence questions are consistently asked at booking and routinely followed up twice during pregnancy, cases examined indicated that, even in those where police notifications had been received, this was not followed up or discussed either additionally as an extra contact or as part of routine enquiry. (**Recommendation 1.3**)

2.12 Birth plans for women whose unborn children are the subject of child protection plans were seen to be robust. However, there is a significant gap in the use of plans for women with vulnerabilities who do not meet these higher thresholds. Assessment of care, safeguarding and subsequent planning for lower level vulnerabilities is weak. (**Recommendation 3.5**)

2.13 We were advised that female genital mutilation (FGM) cases are not deemed prevalent in Herefordshire. However, during our inspection we were not assured what steps have been taken by providers in Hereford to assure themselves of this by way of a policy decision, audit or subject inclusion in staff training. (**Recommendation 5.1**)

2.14 In health visiting we were advised that screening tools are used to assess perinatal mental health and include an antenatal tool and a post natal depression tool. However, in files seen there were no records to evidence the tools being used or recording of scores obtained from the use of those screening tools. This means that there is no record available to measure or inform about perinatal mental health and any potential impact upon caring responsibilities and identified support needs. (**Recommendation 2.3**)

2.15 All young people under 17 attending the ED at County hospital because of alcohol or substance misuse are automatically admitted to the paediatric ward for further assessment. However, we were made aware that relationships with the young people's substance misuse service are not well established and this is an area for development. (**Recommendation 3.6**)

2.16 We were told that the dental health services in Hereford routinely notify via the 'no access policy' of non-attenders, poor dental health or poor presentation at clinics. This is good practice in identifying early help for children. Poor dental hygiene is a key indicator in neglect of children.

2.17 Children, young people and families who need support for their emotional health and wellbeing are able to access some limited provision through family support workers and parenting programmes run through children's centres.

2.18 Children and young people who require targeted support at tier three from CAMHS can be referred into the service by a health or social care professional. Guidance on criteria has recently been revised and practitioners can use the duty CAMHS worker to discuss a referral prior to submitting it. This helps to ensure the appropriateness of the referral and help to avoid any delay.

2.19 Children, young people and families who need referring into the very small CAMHS learning disability service are facing an unacceptable wait for help. Currently, these families are waiting up to six months to access treatment. We were advised that 2GNHSFT is exploring ways to address this. (**Recommendation 4.2**)

2.20 Most children and young people access CAMHS at the Linden Centre. The environment is not child friendly, the waiting area is not confidential and it is shared with adults waiting for other services. Access to therapy rooms is via stairs and this is difficult for parents with pushchairs or individuals using wheelchairs as we were told the lift is unreliable. This is a historic problem and we were advised that there remain no firm plans to address the issue. (**Recommendation 6.1**)

2.21 Children and young people who receive CAMHS support benefit from improved care planning. Those care plans we saw were outcome focussed and most had clear timeframes for completion of work. Children are routinely seen alone and together with their parents. Evaluation and outcome tools are being introduced so that practitioners can better evidence the impact of their work. The IT system clearly indicates where there are concerns around safeguarding or child protection. We saw evidence of risk assessments being updated to reflect any changes to the child's need or disclosure.

2.22 ISH staff have a flexible approach to appointment times and locations, including home visits to help facilitate parental access and engagement with the substance misuse service.

2.23 We saw an organisational commitment to the 'think family' approach in ISH services. 'Think family' is a multi-agency approach to secure better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family services. However, whilst 'think family' is widely understood by ISH professionals, there is more to do to ensure it is strongly embedded in practice, including parenting and family targets in care plans and thorough and ongoing risk assessment for children as a departmental standard to ensure emerging risks are identified. *(A letter will be forwarded to Public Health England bringing their attention to this matter)*

2.24 The ISH team attend MASH strategy meetings and contribute to child protection conferences but significant capacity issues within the team are impacting on this at present.

2.25 School nurse practitioners provide drop in services at high schools across Hereford and we were advised that attendance at these sessions is increasing since their introduction. We were also advised of close working relationships with ISH services centred in Hereford so that school nurse practitioners can provide sexual health support to young people who live in rural areas and who find it difficult to attend the city clinic. This is good practice and relationships have also been developed with rural pharmacies to provide a confidential sexual health service to young people living in these sometimes hard to reach areas. However, the disparate nature of universal service provision including pharmacists could make tracking and identification of risky behaviour and patterns more difficult.

3. Child protection

3.1 ED practitioners are confident about how to refer to children's social care if they are concerned about the safety of a child or young person. There is an electronic form on the HSCB website that practitioners complete and send to the MASH. However, although ED practitioners are expected to print this form and copy it to 2GNHSFT's safeguarding team this is not always routine practice. There is an over reliance on children's social care notifying 2GNHSFT on the numbers of referrals made. This means that it is not possible for the safeguarding team to quality assure referrals or to identify any emerging themes. There has been no corresponding audit to ensure that when a referral is made to children's social care the electronic patient record is updated. Therefore, there is the potential for an incomplete patient record being held and the possibility that staff will not be alerted to any safeguarding concerns should the young person return to the department. **(Recommendation 3.7)**

3.2 Although the paediatric ward at County hospital has good arrangements in place to assess risk and plan for the physical care of young people in mental health crisis to ensure that they are protected from harming themselves and others, young people who are in acute mental health crises do not benefit from timely access to specialist in-patient services. We saw no emergency contingency arrangements between NHS England and local providers on how best to care for a young person under 16 who is acutely unwell. One case examined was of a very mentally unstable young person who was inappropriately placed on a paediatric ward until alternative arrangements could be made to accommodate them. We have been advised that that the young person's physical care was appropriately catered for and their mental health care was appropriately assessed by a consultant psychiatrist and a learning disability nurse. The young person proved to be especially disruptive on the paediatric ward on which they were located.

There is no crises intervention team and access to tier four in-patient beds is limited. We were advised that there is no access to a consultant child psychiatrist out of normal working hours. The case reviewed by inspector's highlighted significant weakness in local arrangements to support the young person who had a sudden and marked deterioration in their mental health. All partners across Herefordshire need to review the incident at to ensure that in future children who need a rapid response are protected and cared for in a planned and co-ordinated way until an appropriate in-patient bed can be found. **(Recommendation 5.2 as at 2.7 above)**

3.3 The identification of children and young people in the care of adults who attend the ED with mental health needs or risk taking behaviours are not always routinely recorded or responded to by ED practitioners. There is an over reliance on the individual practitioner to record the details of the child and then to make a referral to children's social care if they believe the threshold for child protection is met. We were told that practitioners do routinely contact health visitors or school nurses where there were concerns, but we saw no evidence of this recorded on patient records. **(Recommendation 3.8 as at 2.1 above)**

3.4 Child sexual exploitation (CSE) awareness is generally underdeveloped across Herefordshire. There saw no evidence of multi-agency screening tool for CSE being used apart from in CASH services. We saw no evidence in the ED of CSE vulnerability been assessed in young people. (**Recommendation 5.3**)

3.5 Information management in the county is difficult and compounded in part by poor record keeping. In the Ross-On-Wye minor injury unit for example, we found admission paperwork that was incomplete or, when completed, sometimes illegible. On children and young people's admission forms we saw several instances where safeguarding prompts had not been completed, where next of kin details were sparse, coding and discharge summaries were incomplete and the signature box prompt to check computer records for safeguarding and child protection alerts were often left blank. This suggests those important checks had not been completed. We saw little in the way of narrative to explain the nature of the presenting injury and no 'voice of the child'. There is an over reliance on 'staff professional curiosity' which can lead to issues of child safety being missed and not recorded. (**Recommendation 7.1**)

3.6 The patient administration system (PAS) provides the number of previous attendances to the MIU at Ross-on-Wye by young people but does not detail those children and young people who are often asked to re-attend for follow up treatment, such as having a wound re-dressed, and these attendances record on the system as an additional attendance. At other times, children and young people may attend for separate injuries which are also recorded as attendances with a very brief description of the reason for the attendance given.

When the frequency of attendance and the reasons for attendance are not clarified a full history is not seen in context and it is therefore difficult for staff to identify potential areas of concern or need. Recording systems are not robust and children and their families may not be identified as having a need for additional support. (**Recommendation 3.9**)

3.7 There is no electronic record keeping system at Ross-on-Wye MIU apart from the patient administration system (PAS). PAS shows alerts on the system, such as child in need or child protection, but does not specify detail. If a child is subject to child protection plan or is a looked after child (LAC) there is a narrative detailing who to contact for more information but no immediate access to information relating to the child at the time. We were told that medical notes can be requested in preparation for any subsequent visits to the MIU, for example if further dressings or x-rays are required. This means that there is a risk that children will be seen without staff having adequate information available to assess risk and be alert to additional vulnerabilities, especially outside of normal working hours or during busy periods. (**Recommendation 3.10**)

3.8 In midwifery, there is no written mechanism used consistently to alert the safeguarding midwife and other health professionals of additional needs and vulnerabilities, although we are aware this is being explored via the badger net IT system. The current lack of risk assessment means needs are not being comprehensively assessed and documented. Aside from use of common assessment (CAF) framework tools there is no other service health plan specific to types of vulnerabilities. (**Recommendation 3.11**)

3.9 A pre-birth assessment protocol, carried out in conjunction with children's social care, is well embedded into the midwifery service from 12 week gestation to ensure early support in complex cases. This is good practice.

3.10 Arrangements whereby midwives are based in GP cluster surgeries facilitate co-working and opportunities to liaise regularly with GPs, and input on to the EMIS web IT system. Regular monthly maternity liaison meetings between midwifery and health visitors are also in place to exchange information on vulnerable families and identify 'hotspot' areas to ensure resources can be appropriately targeted.

3.11 Referrals made by midwifery professionals to children's social care articulate risk clearly. We saw that the quality of referrals made is good and concerns are consistently identified. However, referrals are not always followed up by contacting the MASH to determine actions to be taken if midwives are not notified beforehand. (**Recommendation 3.12**)

3.12 There is more to do to ensure risks associated with paternal health and lifestyle choices that may have an impact on the unborn/new-born are assessed and recorded at the 'booking in' of new pregnancies. Details of partners for example, are recorded consistently on booking in paperwork but further details including addresses, medical histories, substance misuse etc were not. (**Recommendation 3.11 as at 3.8 above**)

3.13 In midwifery, recording of activity and general documentation management was poor in all cases sampled. Records examined showed no evidence of analysis and evaluation, or clear intervention plans with measurable outcomes. The current way that Badger net system is used highlighted significant issues with fragmentation of information and it was difficult to ascertain the rationale for midwives thinking and decision making. Urgent work on identifying current barriers to good recording practice should be prioritised. (**Recommendation 3.13**)

3.14 GP practices are linked with named health visitors and those health visitors routinely attend GP practice meetings. However, the use of paper records in health visiting and no 'joined up' use or access to GP IT systems presents as a risk that services are working in isolation and without knowledge of wider information from other health professionals which may impact upon the health, development and protection of children. (**Recommendation 2.2 as at 1.12 above**)

We heard about a child who was subject to a child protection plan and a mother who was thought to be abusing alcohol but in denial. In a case discussion meeting between the health visitor and GP the GP had looked on their own IT system and noted that the mother was known by a different name to the child and that records showed that she had had two recent attendances at ED for alcohol related problems.

This information was not previously known to the health visitor (although suspected) who could have planned supportive strategies for both mother and child prior to her meeting with the GP.

3.15 Within health visiting, child protection medicals undertaken by the community paediatrician were seen to have a narrow focus on medical presentation and a parent/carers account, with less consideration given to the impact of environmental factors and additional information provided by other professionals involved. In records seen, the outcome of the medical examination did not cross reference or contextualise the assessments undertaken by other professionals involved despite this information often being provided. Without corroboration of information being provided in relation to the child as part of the background to justify the need for the medical examination, the outcome of the examination cannot be considered robust and complete. (**Recommendation 1.5**)

3.16 We did not see evidence of professional challenge in respect of the outcomes of medical examinations and disparities in findings. We heard that in these instances any concerns would be more likely to be escalated via the safeguarding team rather than direct discussion with the consultant. (**Recommendation 3.14**)

3.17 In CAMHS, a process is in place to receive and respond to invitations to attend key child protection conferences. However, the demand for CAMHS input is considerable and there is not the capacity within the service for practitioners to attend all meetings called around the common assessment framework, child in need and child protection. Together NHSFT are working to develop criteria on response to requests for attendance at meetings by CAMHS practitioners to ensure that they are prioritising and meeting the needs of the most vulnerable families. The trust expects practitioners to provide a report for all child protection conferences regardless of whether they attend. However, this does not happen in all cases. One practitioner told us that they would not prepare a report for conference if they were planning to attend and contribute. There is risk therefore that a practitioner might not be able to attend a meeting due to unforeseen circumstances where a report has not been submitted and therefore potentially important information might not be available to inform that meeting and decision making process. (**Recommendation 6.2**)

3.18 Within DASH services we saw good engagement with formal child protection arrangements, including attendance and contribution to child protection meetings. The use of a standardised template for child protection reports is facilitating high standards of information sharing and analysis of cases and we saw some exemplary work in this area.

3.19 In adult mental health we saw that the patient records system currently in use contains appropriate templates and prompts to enable staff to consider risks to children living with, or accessible to, adults who are experiencing poor mental health. The system enables staff to record actions taken to mitigate any such risks identified. We also saw that the system has key data fields that enable other staff members who view the record to be alerted to the presence of a potentially vulnerable child.

However, in three of the six cases we examined, we noted that the appropriate templates relating to children, such as safeguarding and risk assessment templates, were not completed accurately. This may indicate that staff are not exploring the risks to children effectively or taking appropriate action to mitigate those risks, such as making a MASH referral or pursuing dialogue with other health providers likely to have an interest.

In one case examined we saw that the risks to two very young children arising from their mother's escalating chaotic behaviour had not been considered properly alongside the mother's mental health needs. Over the course of a six week period a number of opportunities were missed to either refer the children to the MASH or to consider passing information to other health agencies that might be best placed to offer support, as below. (**Recommendation 6.3**)

The case examined presented a mother in mental health crisis who had two young children. She demonstrated escalating concerning behaviour and suicidal thoughts.

She was not subject to any referral to MASH and no other information was passed to key health agencies to ensure children were safe or received support despite a number of opportunities to do so over a period of several months.

There was no evidence of staff involved taking the case to supervision for advice. There were inconsistent descriptions of risk to children, with one risk assessment showing the risk as being 'unclear' and another stating that the risk was low. This despite no template risk assessment forms having seen to have been completed to support this assertion.

The 'think family' approach was not evident and due consideration to the clients children was not clear throughout the record examined.

All supportive evidence contained within the file had come from discussions with the client and there was no attempt to follow up the safety of the children despite known risk factors.

Practitioner's failure in the identification and consideration of children's 'lived experience' and associated vulnerabilities is a common feature in serious case reviews.

3.20 In adult mental health, where patients are about to be discharged from in-patient care, other children's health professionals are invited to attend discharge planning meetings so that meeting potentially vulnerable children and young people's needs can be appropriately considered and planned.

3.21 Records from child protection meetings were not routinely placed in client records in adult mental health. We were told that practitioners do not always receive minutes from core group meetings although in records examined we saw little evidence of escalation to children's social care to obtain those important meeting minutes which contain actions for multi-agency partners to adhere to and thus inform the action planning process. (**Recommendation 6.4**)

3.22 There are no agreed and established county wide arrangements for attendance of GPs at initial child protection conferences and other child protection meetings. Likewise, there is no agreed county wide approach to the submission of reports and the information required on them. This is a missed opportunity for GPs across the county to provide information in a standardised format to inform important child protection meetings. (**Recommendation 8.1**)

4. Looked after children

5.3.1 We reviewed a sample of LAC health assessments and noted that the quality was variable with some gaps in the information presented for the LAC reviews. In particular, part C of the reports containing the recommendations for the care plan were often vague, had missing information and were not focused on clear, measurable outcomes. This indicated that dip audits of the quality of these reports was ineffective in identifying those gaps seen.

Furthermore, there was no evidence that recommendations for the health care plans for LAC were being followed up to ensure they had been carried out. This was despite an audit carried out in April 2014 ('as if it were an OFSTED inspection' audit) showing that six out of nine cases of core assessments or LAC assessments were of poor quality, although it is not clear from the documentation we were shown what the resulting audit action plan was. (**Recommendation 8.2**)

5.3.2 We were advised that due to the absence of an electronic records system in LAC it was a challenge to ensure that records were integrated, complete and up-to-date, but that one initiative in place to overcome this was to ensure that each lead professional maintained a chronology of significant events. However, in records examined we found that a chronology had been completed in only one file; all of the other files seen had a chronology template that was either incomplete or not completed at all. This was even in cases where significant events should otherwise have warranted a chronology being maintained. The lack of continuity in the completion of chronologies means the current system is ineffective in ensuring continuity of information across different parts of the health sector. (**Recommendation 1.4**)

5.3.3 In health visiting, a chronology of significant events was seen on all paper records and these were further cross referenced with case notes. Chronologies were seen to be clearly written on yellow pre-printed sheets and easily located. Completion of an up to date chronology is good practice and provides ease of access to significant information in the paper files.

5.3.4 We examined files pertaining to looked after children within the school nursing team and saw that they were all up-to-date, comprehensive and clearly articulated the voice of the child. Chronologies were routinely used across all cases examined and these were easily identified and up-to-date.

5.3.5 Children and young people looked after who need additional support for their emotional health and wellbeing can access a local authority commissioned service, the Herefordshire intensive placement support service, which offers therapy to children in foster care and a consultation service to professionals working with children who are on the periphery of care. 2gether NHSFT has recently seconded two psychologists to the service. We were told that children looked after are considered a priority group within CAMHS and that referrals into the service are monitored.

5.3.6 There is consistency in the county in arrangements for children and young people to have their health needs assessed by a small group of suitably qualified paediatricians. However, we saw some inconsistency in the quality of initial health assessments and associated health planning, particularly for older young people. (**Recommendation 1.5** as at 3.15 above)

5.3.7 Waiting times for health assessments in LAC have reduced to within national guidelines following targeted work and we also saw that strength and difficulties questionnaires (SDQ) scores are used to inform the health assessment process. The SDQ is a brief behavioural screening questionnaire for children and young people. However, health plans seen following an assessment were basic and not specific, measurable, attainable, realistic and timely (SMART). They did not always clearly articulate the voice of the child. Although British Association of Fostering (BAF) forms are used we saw that they vary in format and are not standardised. Drug use screening tools (DUST) used to screen for and identify substance misuse risks are also not routinely used. (**Recommendation 1.5** as at 3.15 and 4.6 above)

5.3.8 The LAC team has established sound arrangements to monitor and understand performance and this has contributed to improvements, e.g. in the timeliness of health assessments. However, the current manual systems are an inefficient use of professional resources and unsustainable given the team's workload. We were advised that work has started and that short term work has been prioritised to establish an electronic solution to generate reliable children in care performance data.

5.3.9 LAC nurses are resourced to provide care and support to young people up to age 18 and we were further advised that health passports are provided to young people aged 16 to 18 by the local authority and not LAC nurses. We examined a blank health passport that we were advised is routinely given to young people on leaving care and saw that there is a section that can be used by health to record health history. We were further advised that the document was designed in conjunction with looked after children and young people. However, LAC professionals we spoke with advised us that the current arrangements to support the health needs of children in care who are aged 16 and above and for those leaving care are in the process of being strengthened, but that current practice is inconsistent. This work is part of new draft CYPP LAC work stream.

We were told, 'Health needs are increasingly being recognised but there is not yet a common pathway (for all)'. This is contradictory to our findings when meeting with foster carers. We were advised by them that health passports are provided to carers to complete from day one of their taking a child into care. Passports examined were routinely completed by carers and included all visits to GPs and dentist, immunisations and other important health histories.

In one passport examined we saw how the foster carer had recorded every attendance by the young person in their care at their GP, dentist, hospital appointment, emergency ED attendance, immunisations and even cuts and bruises treated at home.

Where the young person asked questions about their health these were also recorded and the results of any enquiries made likewise written down.

This is good practice as care leavers we speak with tell of the importance of knowing what their health histories are on leaving care.

5.3.10 The LAC nurse offers health advice through her attendance at fortnightly evening drop in sessions for children in care and this enables engagement with some children and young people who might otherwise be hard to reach.

5.3.11 LAC nurses have also targeted sessions help to meet the needs and contribute to safeguarding for individuals and groups of young people, including 'girls night in' sessions covering personal safety, relationships etc. We were advised that these sessions receive good feedback.

Management

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

5.1 Leadership and management

5.1.1 The CCG have to date been unsuccessful in recruiting to the role of named professional primary care. In order to reduce the impact of this, support for the information sharing processes for child protection procedures come from the current safeguarding team and existing MASH resources. However, the absence of a named GP is recognised as a gap in the governance structure of safeguarding within the CCG and means that there is no single, credible accountable clinician to provide effective safeguarding leadership or impetus for change within primary medical services. This was confirmed in discussion with local GPs who were unclear about the current population of children and young people in Hereford subject to child protection measures. They also demonstrated a varied understanding of the multi-agency risk assessment conference (MARAC) process in relation to sharing information about domestic violence, and the consistent, safe use of read codes safeguarding alerts on their IT systems. (**Recommendation 8.3**)

5.1.2 We saw that the use and understanding of read codes is variable in GP practices. For example, we saw no domestic violence read codes in any practice visited and other codes are used to varying effect, with one GP practice coding a young person as child protection when this was not the case and had not been during their time of registration at the practice. It is a risk that GPs, who are a valuable source of child protection information, will not be aware of issues such as domestic violence in households. (**Recommendation 8.4**)

5.1.3 We were told that notifications from ED attendances can take up to three months to arrive at the health visitor involved with the child. We saw one example of a child who had been discharged from hospital in December 2014; the notification was received by CHD on 6 January 2015 but was not received by the health visiting team until 9 February 2015. This is not acceptable and means that important information pertaining to a child is not being received in a timely manner sufficient to action or follow through. (**Recommendation 1.6**)

5.1.4 The named nurse for the Wye Valley NHS FT is employed full time and is assisted by an additional full time specialist nurse for safeguarding and a whole time administrator. The designated doctor role has two programmed activities with which to allocate their time allocated to them and it is planned to increase this to four. We were advised that the lead anaesthetist for child protection has recently been identified. The named nurse has undertaken safeguarding training appropriate to her post and accesses regular supervision from the designated nurse.

5.1.5 In midwifery, we saw an ongoing culture of learning including the use of 'round table reviews' to discuss complex cases and to change departmental procedures to reflect this learning and improve service provision. Audits are undertaken but outcomes and resultant action plans are not always used effectively to ensure safeguarding risks and additional needs are documented and that practice changes are embedded. (**Recommendation 3.15**)

5.1.6 In midwifery, and following a recent LSCB audit, initial child protection conference reports are now reviewed by the safeguarding midwife, and those sampled reflected a high level of detail and analysis on the part of the health professionals compiling them.

5.1.7 Within health visiting we heard and examined evidence of a strong value base in relation to best outcomes for children, professional curiosity and a desire to strengthen practice. However, the work of the health visiting team is hampered by poor systems for recording, accessing and sharing of information. Case records are paper files with hand written notes. All notes seen were however, signed, dated and hand writing was legible. (**Recommendation as 2.1 at 1.10 above**)

5.1.8 We were unable to access tracked cases with health visitor involvement from one health visitor base. Records have to be requested or viewed at their base locations. Health visitors are reliant upon paper notifications or telephone calls in respect of involvement from other health services or providers. This system is not robust in ensuring that information about children and their carers is up to date and readily accessible to staff. (**Recommendation as 2.1 at 1.10 above**)

5.1.9 There is ongoing and in-depth work by commissioners to better understand the emotional and mental health needs of children and young people across Herefordshire. The mental health needs assessment is now complete and planning is taking place to develop a strategy that will address the needs of children and young people across the spectrum of need. Progress is being made with the introduction of the children and young people's integrated access to psychological therapies (IAPS) and a voluntary sector counselling service has been commissioned to provide a counselling service to children and young people over 10 years old. However, the current CAMH service is small and fragile, case numbers are high and staff retention is problematic. The lack of early intervention and support at tier two means that CAMHS are at the mercy of fluctuating demands for the services that they provide. (**Recommendation 6.5**)

5.1.10 There are effective arrangements in place to ensure young people with enduring mental illness are transitioned safely into adult mental health services. This process involves planning discussions between CAMHS and adult mental health, some joint working before the young person becomes 18 and eventual handover to adult services over a protracted period of time where possible.

5.1.11 Practice managers within the school nurse service routinely select a 'dip sample' of live cases and quality assess them to ensure the best service is being provided and that children are appropriately kept safe. Information gained is then shared with nursing staff by way of feedback and where required, recommendations are made to improve their work with young people.

5.1.12 Health's role in the corporate parenting strategy is recognised and the LAC team maintains regular attendance at the panel which receives performance reports. The LAC nurse is helping to ensure that newly elected members understand the importance of health's contribution and this should help to inform appropriate target setting for health indicators within the next strategic plan.

5.1.13 Comprehensive recording is in place on all cases sampled in ISH services, using the electronic Lillie IT system. This included the use of pop up alerts to ensure staff are aware of additional vulnerabilities and a vulnerability recall system to generate appointments for young people with lower level of concerns who they wish to monitor.

5.1.14 We spoke with health professionals based at the MASH and were advised of the variable nature in GP knowledge of the MASH and MARAC processes. Referrals to the MASH are also variable being considered good from health visitors and school nurses, variable from midwifery and poor/variable from GPs.

Other 'problems' can occur because of the way records are kept in the area. For example, it is often difficult obtaining information from individual health visitors due to their use of paper records and also practitioner locations. It also means there can be a lot of duplication of record keeping. Due to the limited amount of electronic record keeping in Hereford it remains difficult, even with 'read only' access for health practitioners to share information quickly. (**Recommendation 2.2** as at 1.12 above)

5.1.15 Some work has been done by the designated nurse to develop pathways and online information to assist GPs and improve consistency of safeguarding practice. However, more needs to be done to ensure consistency in understanding and the use of these systems such as, for example, a safeguarding template and an on line referral to the MASH. This would be helped by the successful recruitment of a named GP for Hereford to provide better support and guidance to local GP practices. (**Recommendation 8.3** as at 5.1.1 above)

5.1.16 In GP practices visited safeguarding meetings are held with health visitors and, in one case, a midwife as well. However, the arrangements are not sufficiently consistent and robust to ensure needs and risks for children of all ages are identified and mitigated at an early stage. We were advised that the needs of school age children are not part of the agendas of any of these meetings. (**Recommendation 8.5**. A letter will also be forwarded to Public Health England bringing their attention to this matter)

5.1.17 There is an escalation policy in place within integrated sexual health but this appears to be under used and cases sampled highlighted drift and lack of assurance that risks were being managed by other agencies, despite good identification of vulnerability and needs by the integrated sexual health service. (A letter will be forwarded to Public Health bringing their attention to this matter)

5.2 Governance

5.2.1 The County Hospital ED benefits from the support of an audit clerk who regularly checks compliance on elements of safeguarding practice. This includes checks to ensure that practitioners are reviewing the PAS system for alerts, which includes information on children looked after, children who have child protection plans in place and other vulnerabilities or communication needs. Routine checks are also made that practitioners are completing the safeguarding triage. In all records seen in the ED, PAS alerts had been checked and the safeguarding triage tool had been completed.

5.2.2 ED senior practitioners have the opportunity to attend a multi-agency paediatric group with the police, CAMHS, adult psychiatry and children's social care to discuss best practice and how to resolve operational issues. However, due to work pressures, attendance has recently slipped. These meetings are effective in resolving operational boundaries.

5.2.3 The lack of written vulnerability alert forms to notify the safeguarding midwife means there is a lack of assurance that issues have been analysed and actions addressed with appropriate plans in place for mother and unborn. There is a need for more robust operational oversight of safeguarding and vulnerabilities in cases on the periphery of child protection. (**Recommendation 3.16**)

5.2.4 Arrangements in local areas that boundary Herefordshire impact on level and complexity of safeguarding on caseloads held by midwifery practitioners. Hereford has good cross boundary liaison arrangements in place to ensure these women from out of area are supported well.

5.2.5 The CCG have been actively involved in establishing the means for children to input effectively into the provision of services across the county. For example, the provision of a child's voice inbox on the WVNHST email system enables children to leave their feedback. Of more significance was the creation of the consultative forum known as 'children's ambassadors' made up of young people aged between 11-16. The group has already carried out walk-around visits of children's facilities and undertaken interviews of young service users with a view to understanding how services could be improved. Their voice has already led to improvements at the County Hospital ED, the design of information leaflets for young people and bi-weekly 'Saturday club' meetings for children and young people who are waiting to attend the hospital for treatment.

The 'Saturday club' has proven popular with children and young people, putting them more at ease about procedures they might be expected to undergo when receiving treatment at the hospital. It is also an opportunity for health professionals to explain and obtain consent from those with parental responsibility and young people themselves at the time of their visit. Obtaining the views of children and young people who have used health services and then acting on those views where possible is an important aspect in the design of service provision.

5.2.6 Although formal feedback from children and young people accessing school nurse services is not yet sought, we were advised that informal, verbal feedback is routinely obtained. More formal processes are planned as the importance of obtaining it is recognised as an important part of developing and improving service provision.

5.2.7 Lessons learned from a recent serious case review in the area has resulted in the CCG, in corroboration with the Hereford local safeguarding children's board (HSCB), in developing an action plan to address recognised risks to young people, particularly in the 16 to 18 year old age group. This has included increased awareness training for health professionals and the setting up of transition clinics, for example in diabetic care, for young people who are moving from adolescent care to adult care.

5.2.8 The CCG told us that they had commissioned a quality peer review of the CAMHS service carried out by the West Midlands quality review service. 2GNHSFT had responded well to some significant actions required by this review and had already begun to implement changes arising from the action plan, for example, the setting up of an emotional health and wellbeing service, although the effectiveness of this had not been measured. Many of the actions arising from the review, however, had yet to be implemented.

5.2.9 There is no quality assurance process to ensure the quality of children's social care referrals or child protection conference reports within 2gether NHSFT are of a consistently high standard. However, we did see that minutes from conferences and associated child protection plans are uploaded onto the IT system, and on files examined these were available to inform the practitioners work. (**Recommendation 6.6**)

5.2.10 At the time of inspection there were three full time vacancies within health visiting services but we were advised that all vacant posts have now been recruited to. Although some health visitor teams are 'top heavy' with newly qualified staff, those staff are 'paired up' with more experienced professionals to engage in more complex cases so as to better develop safe practice experience. Newly qualified practitioners follow a six month preceptorship programme.

5.2.11 Currently the ISH service is unable to attend a number of external safeguarding meetings due to staffing resources. However, the trust reports that the ISH service has attended many of the multi-agency monthly HSCB and children at specific additional risk (CSAR) operational group meetings. The purpose of the meetings is to gather information so that children at risk of sexual exploitation can be appropriately safeguarded, that plans are in place for all cases that are identified and 'soft' information is used to see how cases are linked. Internal review of individuals known to CSAR show many are known to the sexual health service already.

Additionally, data sharing protocols are reportedly near completion so ISH services are now in a position to share potential perpetrator details with the group where, for example, there are large age disparities or concerns around potential grooming and contacts details of 'potential' perpetrators are known to the service. The CSAR operational and the CSAR strategic group is also supported by a member of either the LAC or safeguarding children team.

However, during our inspection we were advised that the CSAR forum appears to have changed focus and is no longer discussing individuals at risk. The ISH team are unclear if there is an ongoing forum to discuss these cases and feel progress with CSE strategy is slow across county. Although health are well represented at the strategic CSAR meetings, from meeting minutes examined it was difficult to see what discussions and decisions were made in relation to individual cases to safeguard young people at risk. (**Recommendation 8.6.** *A letter will also be forwarded to Public Health bringing their attention to this matter*)

5.3 Training and supervision

5.3.1 Good progress is being made in ensuring all ED practitioners are trained to level three safeguarding following the changes to the intercollegiate guidance and the recruitment of new band five nurses. However, ED practitioners and paediatric ward staff do not access formal supervision in safeguarding children. There is an over-reliance on the ad-hoc support and guidance from the safeguarding team.

5.3.2 Most practitioners working for WVNHSST can access level three safeguarding training through the HSCB or through the trust's internal training offer. The trust's package is a full day and the content is mapped against the intercollegiate guidance. External agencies are commissioned to provide the necessary multi-agency component.

5.3.3 There are currently insufficient numbers of specialist paediatric trained nurses working in the ED. We were advised that it is not possible to roster a paediatric nurse on all shifts. However, WVNHSST has recently recruited additional registered sick children's nurses and has increased the focus on children and safeguarding in the roles of newly appointed senior nurses within urgent care. All senior staff have attended training on recognising the sick child and paediatric immediate life support (PILS) and are working to ensure that all qualified staff have some additional specialist training in working with acutely ill children.

5.3.4 In MIU's visited, all appropriate staff have had training to level three safeguarding which has a multi-agency element in line with intercollegiate guidance. However, we were advised by Ross-on-Wye staff that they have had not had any training in respect of CSE or FGM and this is a gap in their knowledge base, despite us being assured that CSE and FGM is built into the current level three safeguarding package as per intercollegiate guidance. (**Recommendation 3.17**)

5.3.5 We were advised that staff at Ross-on-Wye MIU do not receive regular, structured safeguarding supervision either individually or in groups. This is not in keeping with current recommendations. This means that impact of the work is not monitored and staff are not given an opportunity to reflect upon practice, managers are not aware of failing practice or able to support the development of good practices and identify training needs. (**Recommendation 3.18**)

5.3.6 In midwifery, a robust preceptorship package is in place for all newly qualified staff, including shadowing staff at the safeguarding clinic and time working alongside the safeguarding midwife, attending MARAC etc. to develop a better understanding of the role of safeguarding. We were also advised that the safeguarding midwife also provides training to children's social care employees.

5.3.7 Midwives in the County hospital have access to a high level of ad-hoc support and supervision for safeguarding due to visible presence of safeguarding midwife. Formal scheduled supervision is in place on a quarterly basis but this was not documented on notes examined. We saw evidence of the safeguarding midwife supporting midwives in cases and attending initial child protection conferences, strategy meetings and discharge planning meetings to ensure new born needs were met. However, capacity and lack of administrative support is an issue and due to operational workload, she is unable to undertake managerial oversight on all identified vulnerable cases. (**Recommendation 1.7**)

5.3.8 Midwives have access to a range of training and update opportunities that are monitored by the named team, including quarterly safeguarding forums held jointly between health visitors and midwifery services. However, we were advised that level three safeguarding training is provided 'in house' and as such is not compliant with the latest intercollegiate guidance. (**Recommendation 3.19**)

5.3.9 The recording of supervision across LAC and health visitors is variable. In LAC for example there are arrangements for general oversight of work and sharing learning opportunities but we did not examine any evidence of formal recorded safeguarding supervision. (**Recommendation 2.4**)

5.3.10 Records seen in health visiting show that safeguarding supervision is recorded in the chronology and case notes. However, the recording did not demonstrate reflective discussions or clear action planning. In one case examined the recording from the safeguarding supervision stated that the social worker should be asked to read the file to become familiar with the case. This is not within the remit of the health visitor and is suggestive of tokenistic supervision and not evidence of qualitative reflective safeguarding supervision to inform good practice and ensure that children are safe and protected. However, staff members did tell us that they feel confident in seeking safeguarding advice and guidance from a number of sources if required and said that they would have no hesitation in picking up the telephone to seek support. (**Recommendation 2.5**)

5.3.11 In health visiting, safeguarding training requirements services in line with intercollegiate guidelines. We were told that training information is held centrally and we saw evidence of health visitor practice managers working on a team training audit tool to assist in local team monitoring of attendance at training and in identifying knowledge gaps. Staff have been given a training audit form to complete which will form part of their personal development folder. This ensures that local managers are able to audit and respond to individual staff need and encourages staff to take responsibility for their own learning and professional development.

5.3.12 School nurses receive regular, scheduled and specific safeguarding supervision conducted in both groups or on a one-to-one basis. We were also advised that ad-hoc supervision takes place with the safeguarding lead whenever it is required. In files examined we saw that nurse practitioners routinely record that they have received safeguarding supervision in client notes both on chronologies and in the diary facility. Notes included actions to be followed up by practitioners following the supervision. This is seen as best practice.

5.3.13 Safeguarding children supervision is well embedded in CAMHS. We reviewed evidence of reflective supervision on case notes with clear plans arising out supervision undertaken. CAMHS practitioners have access to scheduled group supervision held every month and attendance is monitored well.

5.3.14 There is more to do to ensure safeguarding supervision is embedded within DASH services. Currently, it is discussed on an adhoc basis within clinical supervision and although there is dedicated time for safeguarding supervision sessions, these were being used variably by different members of staff. There is limited management oversight of safeguarding activity or practices in place to ensure all safeguarding issues have been considered. Notes and actions arising from supervision are not recorded on client records. *(A letter will be forwarded to public health bringing their attention to this matter)*

5.3.15 Formal safeguarding supervision arrangements are in place within the integrated sexual health service. Staff report that they have access to ad-hoc advice and support on request from the named team. However, cases sampled did not show the impact of this and we saw many cases that were drifting and would have benefitted from the oversight of the named safeguarding team to move them forward. *(A letter will be forwarded to Public Health bringing their attention to this matter)*

Recommendations

1. Herefordshire CCG and Wye Valley NHS Trust should:

- 1.1 Audit the reliability of waiting times to access CAMHS services as an aid to the potential review of service targets and provision.
- 1.2 Implement methods to target midwifery support to specialist groups of new and expectant vulnerable mothers including teenage pregnancy, substance misuse and those living with mental health issues.
- 1.3 Implement systems, policies and procedures for staff to follow to enable quality assessments of risk to be conducted within midwifery services for all expectant and new mothers that identify potential vulnerabilities, including domestic violence, and further ensure routine audits are undertaken to ensure the quality and consistency of those assessments.
- 1.4 Review the use of chronologies and then implement methods to better inform complex cases within the LAC team to ensure a more standardised use of them across the service.
- 1.5 Ensure all available information from multi-agency and multi-disciplinary professionals is considered during both initial and review health assessments to provide a more robust and complete assessment across all LAC health ranges and that associated health plans are reflective of all available information..
- 1.6 Improve methods of paediatric liaison between ED practitioners and other health disciplines to ensure better quality and timely notifications of attendances are shared.
- 1.7 Review the safeguarding midwife's role description and support so that effective managerial oversight of identified vulnerable cases in midwifery services can be undertaken.

2. NHS England and Wye Valley NHS Trust should:

- 2.1 Implement more appropriate models, including the potential use of IT systems, for the recording, retention and sharing of client information across Herefordshire.
- 2.2 Promote a standardised interface across Herefordshire for the sharing of information between health visitors and GP surgeries.

- 2.3 Ensure screening tools developed within health visiting services are used appropriately and that information obtained from their use is then used in the support planning process. This also requires regular audit.
- 2.4 Ensure safeguarding supervision is recorded appropriately in client records to include any actions and plans arising from that supervision.
- 2.5 Ensure safeguarding supervision is of a set standard that is both qualitative and reflective in line with ensuring best practice is followed to protect vulnerable young people.

3. Wye Valley NHS Trust should:

- 3.1 Implement a more flexible approach to the pregnancy booking process, especially where risk dictates that environmental and social factors should be better considered.
- 3.2 Implement a more robust system, such as paediatric liaison, to ensure all ED notifications are forwarded to the appropriate health teams in a timely manner and are likewise auditable regarding quality and content.
- 3.3 Ensure staff are appropriately trained and aware in relation to the importance of obtaining the actual weight of children up to age 12 should this be considered necessary and not using estimates of weight, whatever the ensuing prescription.
- 3.4 Continue with plans to improve the triage assessment process in the ED at County Hospital to successfully include vulnerabilities in all young people up to age 18.
- 3.5 Ensure birth plans are considered and implemented where necessary for all expectant mothers with vulnerabilities who do not meet the higher thresholds of child protection procedures.
- 3.6 Implement ways to better develop shared knowledge and information sharing with adolescent substance misuse workers in the county.
- 3.7 Implement systems so that managerial oversight of all referrals made to the MASH can be maintained and routinely audited to ensure quality is maintained and all such referrals are accurately recorded on patient records.
- 3.8 Ensure prompts are included on all adult admission documentation to remind staff of the importance of recording their access to children and young people, especially where adults attend ED following risk taking behaviours. Also ensure staff are appropriately trained to recognise the importance of such questions being asked and that answers are appropriately recorded.

- 3.9 Implement methods to record attendances at provider MIUs according to the attendance reason so that accurate audits can be undertaken and ready identification of additional support requirements can be made.
- 3.10 Implement methods for the additional recording of narrative information following attendance at an MIU and that staff have ready access to important child protection and safeguarding information at the time of attendance.
- 3.11 Review and amend the risk assessment process in midwifery services to ensure a standardised format is used to check vulnerabilities for all expectant mothers, family demographic and other details are recorded and that this information is used to inform appropriate support plans to better safeguard unborn and new born children as well as provide support to vulnerable women and families.
- 3.12 The provider to assure themselves that all staff members are aware of procedures to follow via escalation should they not automatically be made aware of the outcome of referrals made to the MASH.
- 3.13 Ensure staff members receive appropriate training in the use of IT systems within midwifery services and that the recording of activity, analysis and evaluation is standardised across the service.
- 3.14 Encourage staff to feel confident in challenging other professionals (including Consultants) by way of training so that any evidential disparities can be responded to at an early stage
- 3.15 Review and amend the use of action plans following audits undertaken within midwifery services to ensure they are used and monitored effectively.
- 3.16 Implement the use of vulnerability alert forms or an electronic alternative to notify the safeguarding midwife of any concerns so that appropriate managerial oversight can be maintained.
- 3.17 Implement systems to identify gaps in staff knowledge base, including CSE and FGM, across MIU's in Herefordshire and update staff training accordingly.
- 3.18 Ensure structured safeguarding specific supervision is provided to staff working within provider MIUs in line with the latest intercollegiate guidance.
- 3.19 Review level three safeguarding provision across services and amend it to ensure it is in line with the latest intercollegiate guidance.

- 4. Herefordshire CCG and 2gether NHS Foundation Trust should:**
 - 4.1 Assure themselves that appropriate methods are provided to ensure training to paediatric staff in the specific needs and demands of children and young people in mental health crisis and ensure that all staff are aware of the training provision and partake in it.
 - 4.2 Audit the reasons for delays in young people living with learning disabilities accessing CAMH treatment to be better able to implement procedures to reduce those unacceptable delays for this vulnerable client group.

- 5. Herefordshire CCG, NHS England, Wye Valley NHS Trust and 2gether NHS Foundation Trust should:**
 - 5.1 Assure themselves of the prevalence or otherwise of FGM in Herefordshire by way of audit and research and then promote better staff knowledge and understanding of FGM by way of awareness training.
 - 5.2 Review and implement better out-of-hours CAMH service provision to ensure appropriate specialist CAMH cover is available to children and young people in mental health crisis outside of normal office hours.
 - 5.3 All providers and commissioners to review staff awareness and access to training in relation to CSE and FGM, and to further provide appropriate screening tools to staff members to ensure children and young people are checked for their vulnerability whilst in their care.

- 6. 2gether NHS Foundation Trust should:**
 - 6.1 Undertake a full assessment of the layout of the children's waiting area and associated accessibility at the Linden Centre so that due consideration can be given to improving what is now considered an historic problem.
 - 6.2 Ensure reports are provided to inform child protection meetings in all circumstances whether the practitioner intends attendance or not.
 - 6.3 Ensure managerial oversight, appropriate staff training and audit of all risk assessment processes within adult mental health services to assure themselves that all appropriate actions are being considered and taken to protect potentially vulnerable children and young people.
 - 6.4 Ensure practitioners in all disciplines make efforts to obtain minutes from core group meetings to store in client records to ensure the most relevant and up-to-date information is received to better inform safeguarding planning.
 - 6.5 Maintain managerial oversight of CAMH demands so that targeted provision can be considered according to that demand.

- 6.6 Ensure audit and managerial oversight of referrals made to children's social care via the MASH by way of routine dip sample.

7. Herefordshire CCG, Wye Valley NHS Trust and 2gether NHS Foundation Trust should:

- 7.1 Commissioners and providers to review information management across Herefordshire to ensure the recording of information is standardised, complete, up-to-date and easily accessible by other health professionals so that necessary information sharing can take place promptly in relation to child safeguarding.

8. Herefordshire CCG should:

- 8.1 Implement a standardised format on which GPs can submit reports to inform child protection meetings.
- 8.2 Audit the quality of the health assessment process to better inform staff training requirements in the completion of these important documents and follow up action tracking.
- 8.3 Continue and revise efforts to recruit to the role of named professional primary care as a matter of urgency. Also, review oversight of GP practices and their training and support offer in relation to LAC, the use of the MASH and safeguarding children and young people in the absence of a named GP.
- 8.4 Implement the consistent use of read codes in GP practices across the county to include domestic violence alerts and ensure appropriate advice and training is provided where required.
- 8.5 Maintain consistency of meetings between GPs, health visitors and where possible school nurses to better share important information about children and vulnerable families.
- 8.6 Audit, with multi-agency partners, if current CSE forums are fit for purpose and working best to protect vulnerable children and young people and if so that information gained from those meetings is appropriately shared with those professionals working with children, young people and families.

Next steps

An action plan addressing the recommendations above is required from NHS Herefordshire 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.