

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

Children Looked After and Safeguarding

The role of health services in Dorset

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CCGs included:	NHS Dorset
NHS England area:	South of England, Wessex Area Team
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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 Dorset. 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 Dorset, 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 144 children and young people.

Context of the review

The overall population of Dorset, including Poole and Bournemouth is 766,000. Dorset local authority area, which was the area covered in this CLAS review, has a population of 424,559: the majority (95.7%) of Dorset's residents are registered with a practice that is part of NHS Dorset Clinical Commissioning Group (CCG). Children and young people under the age of 20 years make up 20.7% of the population of Dorset with 6.8% of school children being from a minority ethnic group.

Much of Dorset infrastructure operates pan –Dorset and includes the local authorities of Poole and Bournemouth. This CLAS review focuses on Dorset alone, although the inspection team did visit the multi-agency information sharing team (MAIST) located in Poole, which is moving towards becoming a multi-agency safeguarding hub (MASH). The health presence at the MAIST is provided by Dorset HealthCare University NHS Foundation Trust which operates pan-Dorset.

The health and wellbeing of children in Dorset is generally better than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty in Dorset is better than the England average with 12.3% of children aged under 16 years living in poverty. The rate of family homelessness is also better than the England average.

9.4% of children aged 4-5 years and 15.3% of children aged 10-11 years are classified as obese.

In 2013/14, there were 7,675 hospital emergency department (ED) attendances by children aged four years and under. This gives a rate which is lower than the England average. The hospital admission rate for injury in children is higher than the England average, and the admission rate for injury in young people is higher than the England average. Dorset performed worse than the England average in hospital admissions as a result of self-harm for 10-24 year-olds.

In October 2014, the Dorset children's services overview committee discussed a report by the Director for Children's Services that responded to the Young Minds report that highlighted national concerns about funding for CAMHS. The report described the local arrangements for supporting mental health, and the actions being taken to address issues. An update was provided in March 2015 which detailed the outcome of the commissioned review on waiting times and the progress being made in addressing the outstanding recommendations. Minutes from June 2015 confirm that a five year transformation programme for Children's Services "Forward Together for Children" has commenced. In June 2015 the committee considered a report by the Director for Children's Services that updated members on the findings of a review of Pan-Dorset CAMHS provision across Dorset, Bournemouth and Poole and its impact upon Dorset.

The DfE reports that in 2014 there were 230 children in Dorset who had been looked after continuously for at least 12 months. Of these, 200 (87.0%) had their immunisations up to date and had had their teeth checked by a dentist in the last 12 months, while 205 (89.1%) had received their annual health check. All of these are slightly higher than the England averages. There were 30 children under the age of five years looked after for at least 12 months continuously; 25 of these had their development assessments up to date.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Dorset. Higher scores indicate potential emotional or mental health difficulties. The average score per child was 14.1, slightly higher than the England average of 13.9. Dorset had 18% of children classed as borderline cause for concern, and 36% classed as cause for concern, compared to England averages of 13% and 37% respectively.

The number of looked after children has been rising in Dorset over recent time and in September 2015, there were 424 children in the care of the local authority.

The numbers of children subject to child protection plans in Dorset in 2014-15 was 374. This is a 39% increase from 2013-14. 2013-14 data shows that the rate of children subject to child protection plans per 10,000 children in 2013-14 was 35 in Dorset, compared with a rate of 42 nationally.

Commissioning and planning of most health services for children are carried out by NHS Dorset Clinical Commissioning Group (CCG)

Commissioning arrangements for looked-after children's health and the designated roles are the responsibility of NHS Dorset CCG. The looked-after children's health team and operational looked-after children's nurse/s are provided by Dorset HealthCare University NHS Foundation Trust and medical services covering initial health assessments (IHA's) and adoption medicals are provided by Poole Hospital NHS Foundation Trust.

Acute hospital services are provided by Dorset County Hospital NHS Foundation Trust. NHS Dorset CCG also commissions acute hospital services from Poole, Bournemouth and Southampton Hospitals that are outside of the scope of this review.

Health visitor services are commissioned by Public Health Dorset and provided by Dorset HealthCare University NHS Foundation Trust. Health visitor services for Lyme Regis are commissioned by NHS England and provided by Virgin Doctors Ltd as part of a primary and community services contract.

The main school nurse service is commissioned by Public Health Dorset and provided by Dorset Healthcare University Foundation NHS Trust. School nurse services for Lyme Regis are commissioned by NHS England and provided by Virgin Doctors Ltd as part of a primary and community services contract. NHS England commission immunisation services from Dorset Health Care School Nursing service for school aged children across the whole of Dorset.

Contraception and sexual health services (CASH) are commissioned by Public Health Dorset and provided by Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust.

Young people's substance misuse services are commissioned by the children's services of the three local authorities; Poole, Bournemouth and Dorset. In Dorset the provider is 'SHADOWS' who are part of Essential Drug and Alcohol Service (EDAS).

Adult substance misuse services are commissioned by Public Health Dorset and provided by Dorset HealthCare University NHS Foundation Trust's community alcohol and drug advisory service (CADAS), Essential Drug and Alcohol Service, EDP Drug and Alcohol services and Turning Point.

Child and adolescent mental health services (CAMHS) are provided by Dorset HealthCare University NHS Foundation Trust.

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

Specialist facilities are provided as follows: the sexual assault referral centre (SARC) is provided by G4S with support from local paediatricians. Pebble Lodge, CAMHS adolescent mental health in-patient (Tier 4) unit, is provided by Dorset HealthCare University NHS Foundation Trust and child sexual exploitation and missing children's services are provided by Barnardo's.

*The last inspection of health services for Dorset's children took place in 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The contribution of health agencies to keeping children and young people safe was found to be **good**. For looked-after children, the Being Healthy outcome area was found to be **adequate**. Recommendations from that inspection are covered in this review.*

The report

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

What people told us

We spoke with foster carers who told us of delays in the initial health assessment process;

"We have had our current child for 10 weeks now and they still haven't had their first assessment. We were due one last month but that was cancelled. We have another appointment later this week in Poole, which is a long drive for us."

When asked if they had received an explanation for the cancellation and subsequent delay in the assessment taking place they told us;

"We were not told why the previous appointment was cancelled. We don't even get copies of the health report once they are completed although the doctor is usually pretty good at telling us at the time of the medical. I'm worried though about the potential implications for such a late assessment taking place. What if the baby had been covered in bruises? They would likely have healed by now and surely that is a risk to us as carers. We could get the blame if there was something wrong with the baby that hadn't been picked up earlier."

The foster carers went on to tell us of previous experience in delays for initial health assessments taking place and a lack of communication in explaining the reasons for this. They told us;

“I guess it’s because they are so busy, but that’s just a guess. The first appointment was local but the Poole appointment is a good hour’s drive away at a hospital we don’t know. It’s going to be a lot of hassle for us. There is no flexibility as to where the assessments take place. We are never given a choice”

When asked about their experience of health visitor services they told us;

“Health visitors are really good. We usually have the same nurse and we know how to contact her if we need anything and she is really helpful. Always there when needed.”

When asked about GPs they said;

“Our GP will always see us the same day if needed. We have been fostering for a long time now and we never have a problem getting an appointment. If ever we have to take a child to accident and emergency we are always asked if the child is looked after but we then have to wait in line with everyone else. That’s fine I guess, even though the child is looked after.”

When asked about training foster carers said;

“We get plenty of training. We did an attachment course run by CAMHS and the CAMHS psychologist. It was really good. The CAMHS psychologist is excellent. She is so supportive, always there when you need her, she speaks with experience. She comes to some of our evening meetings and really understands us.”

We spoke with young people currently in care in Dorset. When asked about their review health assessments on told us;

“They’re fine. I’m not kept hanging around, they are to the point and get everything that’s needed quite efficiently. The information then goes onto my care plan and I sign it to consent to what’s in it.”

However, another young person currently in care told us;

“I haven’t seen my care plan for years, since probably around 2010; I don’t know what’s in it. I certainly don’t get asked to sign for anything. It doesn’t bother me though as I’m really not all that interested.”

We asked a care leaver about their experiences of health assessments. They told us;

"I don't like the fact that we don't get a choice about the sex of the person doing the medical. I remember my initial health assessment when I went into care and it was so horrible it's put me off even visiting a GP. There is no way I would let someone of the opposite sex do a medical on me again. We should at least be given a choice. It's put me off for life."

Care leavers told us what information they are given when leaving care. One told us;

"I was given a copy of my birth certificate and that's all, nothing else."

Another told us;

"I don't even know what blood group I am. I didn't get anything like that"

They went on to tell us;

"I got a letter from CAMHS once after I had an assessment with them. There was stuff in the letter that I was never told about, stuff about my parents. It was the kind of thing that could explain why I am the way I am. It felt really odd finding out that way, I should have been told about it ages ago. I suppose that is the type of stuff that should be given to us when we leave care as well."

We spoke with a young person who had recently left care and had transitioned from the child and adolescent mental health service (CAMHS) to adult mental health services. They told us;

"It's not as good in the adult system, it's much more 'matter of fact' and doesn't feel so supportive. I had got to know my CAMHS worker really well and the move seemed very sudden. I'll get used to it of course, I have to. It's one of those things I suppose."

When asked about the availability of health advice and information, one young person currently in care told us;

"If I want to know something I have to go and ask for it. It would be nice to know what sort of things are available because if I don't know what's there how will I know what to ask for? I could be really worried about something and think there is no help out there when in reality there is a leaflet or someone I can talk to so as to get advice."

A young mother who was a care leaver told us of her experiences during pregnancy;

"I never got to see the same midwife twice. Every time I went for an appointment it was a different nurse. Some were OK but a couple contradicted each other. One told me I should cut down on my smoking rather than give it up completely as that would be too stressful. The other one had a go at me telling me I should give up all together. That didn't help.

My health visitor is brilliant though. It's always the same one and when she's off then I know who else to speak to. My health visitor is nearly always there to talk to and advise me."

One young person currently in care told us;

"I know my foster carers keep a diary on me and that includes any visits to a GP but I'm apparently not allowed to look at it or comment on it. That doesn't feel right. It's a book about me but I can't see it."

We asked young people about their experience of school nurses. One told us;

"I don't think we have a school nurse at our school. The receptionist is a first aider but no school nurse."

Another told us;

"I don't trust my school nurse. I wouldn't tell her anything. She's too judgemental."

A young mum told us;

"My health visitor is brilliant. It's always the same one and when she's off then I know who else to speak to. My health visitor is nearly always there to talk to and advise me. She's great and takes some of the stress out of being a mum."

Another young mum told us;

"I heard about what the children's centre offered from my sister who had come here. I didn't get any information about it from my midwife, health visitor or GP. I get such good support from the children's centre. It's been a real confidence boost. I've met lots of people and made real friends, which is something I have found difficult in the past. We meet up for coffee outside of the centre. I love coming here and come twice a week if I can".

She went on to say;

"When my baby was unwell, I saw three different GPs. I knew something was wrong but they didn't seem to believe me. I went to the health visitor who has been brilliant. She went through everything with me and told me about safe medicines I could give the baby if she wasn't well. Such a relief and so supportive".

We spoke to new mothers and their partners in the maternity ward. They said;

“Amazing care, especially in labour, the midwife was amazing. The student midwives; at first I didn’t want them involved but they have been phenomenal”

“Everyone has been extremely efficient and helpful, I have been really impressed. It’s been a positive experience all round. Theatre staff were brilliant, couldn’t have asked for anything better”

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 Pregnant women access maternity services at Dorset County Hospital either through their GP Practice or they can self-refer into the service, which is what the majority of women choose to do. We saw evidence that midwives have a flexible approach to conducting antenatal appointments in a variety of settings. Most bookings are conducted at a woman’s home address with the majority of follow on antenatal appointments being held at midwifery antenatal clinics in GP surgeries or children’s centres. However, further home visits are arranged if appropriate. This is good practice and helps midwives to have a better understanding of the women’s home circumstances which may have an impact on their wellbeing.
- 1.2 Midwives routinely inform GPs of a woman’s pregnancy and request a summary of care including any known social concerns. GPs hold essential information about patients current and historical health and social issues which may impact on parenting capacity, so accessing this information is an essential and useful part of risk assessing potential harm to an unborn.

- 1.3 Although no vulnerable women's multi-agency meetings are held at Dorset County Hospital, we saw case evidence of good liaison between midwives and other professionals such as health visiting, social workers, drug and alcohol and adult mental health services to ensure a co-ordinated approach to supporting families. We heard that midwives "hot desk" at children's centres and that they are good at getting new mums, especially those expectant women aged under 23 years, engaged with the children's and are routinely referring to early help resources where necessary. We also saw evidence of good midwifery liaison with other trusts' safeguarding professionals to ensure expectant women who moved frequently between areas are followed up appropriately.
- 1.4 The specialist perinatal mental health service is not currently provided in the west of the county and therefore not all women who would be eligible for this support in Dorset have access to a specialist service and this is not compliant with NICE guidance. Partner commissioners recognise this gap in provision and the service is currently being extended through commissioning arrangements to be provided Pan-Dorset (**Recommendation 5.1**).
- 1.5 A good teenage pregnancy service, provided by two teenage pregnancy lead midwives, is available to teenage parents in certain areas of the county. This service was recently reinstated in Sept 2015. The previous service demonstrated improved outcomes for teenagers but this revised project has not been in place for long enough to evidence outcomes as yet. Where the service is provided this ensures an enhanced multi-agency package for this vulnerable group which evaluates well with service users. However, we noted geographic variability in the provision of this service meaning not all eligible teenagers may be benefiting from this specialist support (**Recommendation 2.1**).
- 1.6 Families of children under five years old living in Dorset benefit from a good delivery of the Healthy Child programme by health visitors. Nursery nurses are working with guidance from health visitors and focus on early help support in the initial phases of parenthood including a follow on from the nurture group for under one year olds.
- 1.7 There are no specialist health visitor roles within the core health visitor service for vulnerable cohorts and it was not clear whether the possible need for specialisms in health visiting has been fully explored and considered by commissioners and provider. *This has been drawn to the attention of Public Health Dorset as the commissioner of the health visitor service.*

- 1.8 All families who transfer into Dorset health visiting services are provided with a home visit. Initial telephone contact is made with the parent within five days of notification to make introductions and arrange an appointment which is confirmed by letter. This ensures that all families are given an early opportunity to meet the health visitor and hear about services that are on offer. Engagement and co-operative working with children's centres is good and we heard about a number of cases where vulnerable families had received good early help support through team around the family and team around the child approaches leading to good outcomes. A children's centre manager told us that it is rare for a health visitor to make a referral about a child that the children's centre is not already aware of due to having discussed cases at the biweekly children's centre and health visitor meetings.

Good Practice Example: *Children's centres work in close co-operation with health visitors in Dorset to provide effective very early help support to families. Little Wrighglers are joint children's centre and health visitor facilitated structured groups which help engage new parents with other parents in their locality. Growing Together is a children's centre based programme focused on parents developing good attachment with their baby.*

Case Example: *A new mother experienced significant post-natal depression and was struggling to cope with her new baby. The health visitor referred the case to children's social care and mum was supported by the adult mental health service for a short period of time. Initially, mum, had lost her confidence and was reluctant to join a group at the children's centre as she felt other mothers would perceive her as a failure as a mother.*

With encouragement, mum engaged well with the children's centre and attended the baby massage group. The health visitor maintained close contact with mum and early help support was provided by the children's centre outreach worker. She engages well with the children's centre and attends clinics regularly, meets her health visitor there and attends the stay and play sessions with other mums. The case is now closed to adult mental health and Mum's emotional health is managed by the GP.

Outcomes:

- *The baby is thriving*
- *Mum's expectations of herself have become more realistic*
- *She is expecting another baby*

This case demonstrates the benefit of a strong early help offer and effective multi-disciplinary working producing good outcomes for mother and child.

- 1.9 All new families benefit from a complete assessment of their situation by their health visitor including home environment, parental mental health, occupation, finance and impact upon the parents' ability to parent. It is common practice for these visits to be undertaken jointly with children's centre staff. Service provision is detailed in entries on the individual case record and reviewed regularly as part of subsequent visiting.

Case Example: *A family had just moved into Dorset from another authority area with two small children, one a baby and the other a toddler.*

The health visitor met with the family and brought them into the children's centre to introduce them to the Little Wrigglers group. There were some early indicators of the family and children being vulnerable. The children were often attending the children's centre without any food being provided with other signs of low level neglect. The health visitor identified that the family's housing environment was deteriorating and they were making high use of the local foodbank.

A children's centre outreach worker was introduced to support the family and the practitioners quickly identified that the situation was worsening with the mother displaying increasing signs of maternal mental health problems. The elder child was often scapegoated and treated differently from the younger child and was excluded from family outings. On undertaking a joint home visit, the health visitor and children's centre worker found the children were strapped into pushchairs and the mother was not prioritising the children's needs.

The Graded Care Profile was used to assess the level of neglect and the case was progressed to an initial child protection case conference (ICPC) and both the children made subject to child protection plans. The elder child lived temporarily with extended family while the parents addressed issues with the home environment. Mum and dad engaged with Little Wrigglers and Growing Together.

There have been improvements and some good outcomes;

- The children are doing well in terms of their health and wellbeing*
- Family hygiene has improved and the children are clean.*
- Parents provide food for the children while at the nursery*
- Attachment between the mother and elder child is demonstrably improved*

In this case, early help was offered, accepted and achieved some positive change; practitioners worked effectively together to identify escalating risk and take appropriate steps to protect the children.

- 1.10 There is a clear pathway for transfer of cases between health visitors and school nurses. Formal handover transfers take place at a face to face meeting at some point after the child's fourth birthday. There is inbuilt flexibility within the arrangements to accommodate individual children's needs and in some cases the transfer does not take place until the child reaches five years of age. This ensures continuity of service until the most appropriate time for the child and their parent. We were told that children receiving an enhanced service offer from health visitors at universal plus or partnership plus would be verbally handed over to the school nurse at transition. In most cases we saw with one exception, the transfer pathway had worked well.
- 1.11 We were told that there is not a recognised single assessment tool used by school nurses to assess the needs of children and young people. Assessment is driven by the judgement of practitioners. In the absence of a benchmarked assessment process there is a risk of variability in the standard of practice. We could see no audit or monitoring process in place to provide assurance and reports on the effectiveness of this and other areas of school nurse practice. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.*
- 1.12 The school nurse service is commissioned to undertake a range of duties including a review of health needs using a questionnaire at school entry when a child is aged five. This does not extend to include the recommended additional staged contacts at transition from primary to secondary school and mid-teens outlined in the Healthy Child Programme 5-19. There were reportedly no plans to develop this. This potentially restricts the opportunity for school nurses to pro-actively search for health needs at other key stages in the child's life and intervene with early help if indicated. We were informed that school nurses hold regular drop-ins in schools that young people can attend alongside a referral system that school staff can refer a young person to the school nurse for issues raised at any point in a child/young person's education.
- 1.13 CAMHS practitioners undertake consultation meetings with school nurses to offer advice and guidance in the care of vulnerable young people and these have been well attended. CAMHS tier two practitioners are now providing more structured support to teachers and pastoral workers in schools to better care for vulnerable children and young people, particularly in areas where there is a shortage of school nurse provision. This is helping to develop early help support to young people with emotional difficulties.
- 1.14 CAMHS practitioners are flexible in where they meet with children and young people. Practitioners meet young people at locations of the young person's choice where risk assessment allows. This is good practice and promotes the young person's engagement with services.

- 1.15 The minor injury units (MIUs) have good arrangements to notify GPs and health visitors about the clinical details of MIU attendances. Copies of details on the attendance and outcomes are sent to the health visitor or school nurse service depending upon the age of the child. Children's social care are sent a copy letter if it is known that a social worker is involved. However, there is insufficient signage to let parents, carers and young people know that details of their attendance at the MIU will be shared with their GP and other health care professionals (**Recommendation 1.1**).
- 1.16 A triage system has been trialled in the Weymouth MIU since the CQC inspection earlier this year and discussions are ongoing with commissioners regarding the formal triage system to be adopted. Attendances within the previous 6 months are flagged up on the information system and discharge letter but this could usefully be extended to a one year period to enable a better overview of patterns of attendance. It was not clear to what extent frequency of presentation was considered by practitioners in their risk assessment. There is little point in making important information available to practitioners if this is then not used to inform decision making. Frequent attendance at emergency settings is a common finding in serious case reviews. (**Recommendation 1.2**).
- 1.17 The presence of a child with an adult attendee is considered by MIU practitioners in the context of safeguarding or child protection. However, there is no clear process to demonstrate that staff are alert to the hidden child who may be at risk from adult attendees. Although MIU practitioners were able to describe how they would ask questions in respect of lifestyle and caring responsibilities, this was not clearly evidenced in records seen. We saw variable practice in the extent of detail recorded; relating to the timing of incidents, circumstances, probing of discrepancies, family history, consent and parental responsibility. Some cases demonstrated a lack of professional curiosity. The safeguarding questionnaire used does not require the practitioner to summarise and analyse risks and make a professional and recorded assessment about any safeguarding action needed. There is no paediatric liaison role at the MIUs and therefore no second look at child attendees to ensure the potential for overlooking risks or vulnerabilities are minimised. (**Recommendations 1.3 and 1.4**).

Case Example: A mother aged 19 with her 10 month old baby attended an MIU in mid-afternoon. She told the practitioner that when she got the baby up that morning, she had found a red mark round the baby's neck, made by the string on the breast feeding pillow.

The information system case record showed the young mother had history of depression and mental health needs. Following incidents of domestic violence in the Summer, she was separated from her partner. The mother had previously declined support from the health visiting service. The record also stated that the baby was bottle fed from 6 months.

There was no evidence in the case notes of the practitioner questioning the mother about the delay in attending the MIU or safety issues relating to how the child slept or probing the circumstances of the how the injury was incurred. There was no discussion with the mum why the baby was apparently sleeping on a breast feeding pillow when he was now bottle fed.

There was no record of any MIU contact directly to the health visitor or the woman's GP or any enquiry made to children's social care as to whether they knew the family.

On reviewing this case, senior staff in the MIU agreed this case merited further curiosity and follow up by the practitioner.

- 1.18 When adults with mental health problems attend the MIUs, practitioners check their records system, , to see if there are any letters from adult mental health services uploaded by the GP surgeries indicating the person is known to mental health services. Not all GP surgeries are using the same electronic patient record however and it was not clear what action the practitioner would take in those circumstances. Unless contact with the person's GP is made routinely where there are concerns about mental health and access to the primary care record system is not an option, there is a potential gap in information gathering which could weaken the practitioner's analysis of risk.
- 1.19 MIU practitioners liaise well with paediatric teams in acute hospitals and refer children appropriately for clinical treatment.
- 1.20 Most children and young people attending Dorset County Hospital emergency department (ED) are seen promptly. Next of kin details are routinely documented but who is accompanying the child to the department is not explicitly recorded within any section of the records. This should include full names and relationship; "mum" or "dad" is insufficient. Poor information recording at this early stage is a feature of serious case reviews and is particularly important in a fractured family with complex dynamics where the recording of name is as relevant as the reported relationship (**Recommendation 2.2**).

- 1.21 Children and their parents or carers wait in a small dedicated child friendly waiting area. However, the children cannot be easily seen or monitored by nursing or medical staff and therefore the potential for a deteriorating child to be missed is possible (**Recommendation 2.3**).
- 1.22 The date of a child or young person's last ED attendance and their total number of ED attendances within the previous twelve months is recorded although it was not clear how this informs any assessment of risk. The relevance of previous attendances is reliant upon individual practitioner's judgement as to whether any review or action is needed. There is scope to include further trigger questions and prompts within the documentation to fully guide and support practitioners safeguarding risk assessments and ensure full compliance with NICE guidance and facilitate operational oversight of risk assessment practice (**Recommendation 2.4**).
- 1.23 We found that adult records are used for young people aged 17+ which does present a risk that clinicians may not be immediately prompted that they are dealing with a child. This has been identified as an information system issue at a national level and has been notified to the national designated network by the CCG's designated nurse. As a result of this finding the named nurse at the acute trust has alerted the information system provider of this anomaly and has put immediate measures in place to override the system and ensure that this cohort of young people is clearly identifiable as children.
- 1.24 ED practitioners are not consistently recording whether an adult patient has caring responsibilities for a child and there is no prompt within adult records to remind clinicians to routinely gather this information. It is important that ED practitioners are able to identify and safeguard the "hidden child" of parents who attend ED with behaviours which may negatively impact on their parenting capacity. We were informed that staff did refer cases of concern and we did see a referral to children's social care where concerns about a parental attendance had been identified, but as this appears to be totally reliant upon professional curiosity and judgement we are not assured that the impact of parental behaviour on children is always considered (**Recommendation 2.5**).
- 1.25 GPs are routinely notified of all attendances at EDs and MIUs. GP practices we visited make good use of this information; ensuring prompt coding on the patient record system and regular reviews of all ED and MIU attendances by children which facilitates the early identification of emerging vulnerability or risks. In one surgery, the risk of the practice being unaware of children and young people presenting at different MIUs for example is significantly reduced because the lead child safeguarding GP reviews all attendances on a monthly basis. In another surgery administration staff review attendances; code them accordingly and enter the details onto SystmOne. Regular audit ensures multiple attendances are brought to the attention of the practice safeguarding lead GP who is then able to consider whether further safeguarding or follow-up action is required.

- 1.26 GPs told us that summaries of the reasons for attendances at MIUs were generally good, detailed and inclusive of information regarding any safeguarding issues. Details of the circumstances surrounding a child's attendance at the ED are often scant however, prompting the GP to follow up with the ED to seek more information (**Recommendation 2.6**).
- 1.27 In one GP practice we saw how all new registrations at the surgery are reviewed by the safeguarding lead GP and, whilst waiting for their old patient records to arrive, the lead GP then contacts the previous surgery to ascertain whether there have been any identified vulnerabilities or child protection concerns. This positive approach to early identification of need in a family is to be commended.
- 1.28 An integrated genito-urinary medicine (GUM) and contraception service is delivered at Weymouth GUM, this is well used by young people for whom multiple appointments or travel outside the county would be a disincentive to attend. The availability of specialist medical practitioners in the GUM service, and two youth clinics supports the delivery of sexual health services to young people with complex needs well.
- 1.29 Contraception and sexual health (CASH) and GUM services use current and appropriate information gathering tools to help their identification of young people who may be vulnerable to exploitation or abuse. A recent audit on outcomes of presentations of 16 and 17 year olds to CASH and GUM showed how the additional information gathered by enhanced risk assessment was effective in identifying and providing help for issues of concern to a high proportion of the young people where otherwise these issues would not have been mentioned. We felt there was scope to strengthen the risk assessment further by including recording and consideration of the demeanour of the young person as part of their assessment as non-verbal indicators observed by the practitioner can usefully further support a comprehensive evaluation of risk .
- 1.30 The adult substance misuse service, Community Alcohol and Drug Advisory Service (CADAS) has devised an assessment tool to assess the impact of parental drug or alcohol use upon children. It prompts for summarisation of the findings, asks if a referral needs to be made for common assessment framework (CAF) or to social care. The expectation is that the assessment will be considered by the multi-disciplinary team (MDT), signed and dated by the practitioner and appropriate action taken. This is good practice in helping to engage families and vulnerable children with early help support

2. Children in need

- 2.1 In the midwifery service, information sharing forms are used consistently to alert the lead midwife for safeguarding children of women's additional needs or vulnerabilities. Police notifications of domestic violence incidents were seen within notes sampled and we were advised that maternity services routinely receive all police reports where women report they are pregnant. All forms are reviewed and followed up by the lead midwife for safeguarding children, to ensure appropriate actions are taken. We did note that these information sheets tend to merge with other paperwork in patients notes and would benefit from being more immediately visible, particularly the plan around birth.
- 2.2 Pregnant women are not seen alone by midwives in a scheduled or planned appointment in their pregnancy to discuss possible domestic violence or sensitive social or medical issues; rather this takes place on an ad hoc basis during the pregnancy. This could be resolved by informing women in the antenatal appointment care plan that on at least one visit they will be seen on their own. This reduces reliance on professional confidence in asking an accompanying adult to leave a consultation and standardises practice for all women. Although questions around domestic violence are included on the social history form, it was not clear that subsequent risk assessments beyond the initial assessment are undertaken to identify any emerging risks or vulnerabilities. Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy. We could not be assured that robust processes are in place to support the identification of women who are experiencing domestic violence or their referral to appropriate support services (**Recommendation 2.7**).

Case Example: *A family with a two year old child were moved into new accommodation from a flat where drugs paraphernalia had been found as the result of an emergency team around the family (TAF) being put in place. Services involved included the midwife, health visitor, children's centre and the housing association which quickly identified more suitable accommodation and facilitated the move.*

The mother, who had previously been in a violent relationship with her elder child's father, was expecting a second child. The father of the unborn had Asperger's Syndrome and found it difficult to deal with noise and changes in routine. The health visitor referred the case to children's social care through the integrated duty team. The decision was to put the child on a common assessment framework (CAF) with the health visitor as lead professional.

Mum and dad engaged with Incredible Years with one-to-one support. This is a 12 week evidence-based parenting programme with a focus on attachment and helping the parents to develop self-help strategies in how to lower their own levels of stress and anxiety. The GP gave information and advice about dad's medication although was not directly part of the TAF.

Outcomes;

- *Family housed in more appropriate accommodation*
- *Mum attending Tea and Toast baby clinic at a local hall.*
- *Both parents are better prepared for the new baby*
- *Both parents are well engaged with support services prior to baby's birth*

- 2.3 School nurses are not using documentation with prompts and trigger questions to aid their assessment of risk for those children and young people presenting with mental health difficulties. While practitioners have had some training on mental health and are offered regular CAMHS consultation, emotional and mental health assessment is reliant on the individual practitioner's knowledge and ability rather than well supported through an agreed template. A systematic approach to assessment would support consistent practice and facilitate managerial quality assurance. The voice of the child was not consistently strong in school nurses' case records. *This has been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.*

- 2.4 At Dorset County Hospital ED, vulnerable children are flagged on the hospital's information system. Flagging is reliant upon a variable range of sources and currently the hospital receives routine notification of all Dorset child protection case conferences directly from children's social care. However they are not routinely informed about CIN or LAC which could enhance hospital practitioners risk assessment. Children and young people who attend the ED and do not wait for treatment are followed up by staff. However, there is no formal policy to inform decision making and there is an over-reliance on individual practitioner response. We were advised that the trust is developing a Did Not Wait policy and pathway for staff to follow **(Recommendation 2.8)**.
- 2.5 Young people who attend ED following misuse of alcohol or substances are routinely referred to "Shadows" drug and alcohol service. This is good practice in identifying and supporting a young person engaged in risk taking behaviours to engage with early support.
- 2.6 CAMHS contribute to care plans and liaise with patients and staff on the paediatric ward well. We were told that occasionally, in challenging and complex cases, CAMHS have provided staff to support paediatric nursing staff in the safe care of an inpatient with mental health issues. This is a demonstration of good and effective joint working.
- 2.7 There is an acknowledged challenge around access to CAMHS which is subject to rigorous monitoring pan-Dorset and within the county's locality areas. CAMHS managers told us of an increasing number of young mothers and expectant mothers entering into the service, although the reasons for this were unclear. Cases are assessed and discussed at team meetings to decide if tier two or tier three interventions are appropriate and what risks are present before an appointment is made; generally within a further eight weeks. The outcome of the assessment is then shared with the person making the initial referral which is good practice facilitating the referrer, often a GP, to plan their own interventions accordingly. Children and young people are offered cognitive behavioural therapy (CBT) where appropriate.
- 2.8 Children and young people awaiting both assessment and an appointment are monitored by practitioners on a monthly basis either in a face-to-face meeting or over the telephone according to the level of assessed risk. These meetings take place more regularly if the assessed risk changes. GPs we visited however were not aware of CAMHS practitioners maintaining contact with young people on their waiting lists. GPs also spoke of some frustration in the lack of alternative therapies available to support young people with emotional health needs.

- 2.9 Cases we reviewed in CAMHS, demonstrated timely and detailed assessments being undertaken by practitioners within eight weeks of referral for the most part. All cases examined demonstrated CAMHS practitioners undertaking detailed assessments with their clients and also reviewing information provided by other agencies where available. There were six young people awaiting therapeutic interventions at tier three at the time of this inspection, although it was not clear how long they had been waiting. Risk assessments for individual children engaged with CAMHS are not always routinely updated. In one case we saw, recent history of deliberate self-harm had not influenced a review of care or update on their risk assessment (**Recommendation 1.5**).

Case Example: *A young person engaged with CAMHS had three attendances at ED within two weeks requiring medical interventions.*

Progress notes on the young person's CAMHS case record noted a referral to CAMHS by the young person's father and clearly detailed consistent contact between the CAMHS practitioner and the young person.

The young person's risk assessment was not updated within the client's electronic case record. It is important that individual risk, especially where recent history indicates escalating risk, results in an updated risk assessment so that individual care can be planned and recorded accordingly.

- 2.10 The professionals telephone advice service (PTAS) provides multi-agency professionals with advice on the type of services that CAMHS can provide and where to go for further support if required. CAMHS practitioners told us that the service is under used with advice being sought more often from the CAMHS on-call duty worker. We understand there are plans in place to better publicise the PTAS to encourage its use.
- 2.11 In CAMHS, case evidence demonstrated that practitioners have a good understanding and recognition of risks posed to potentially vulnerable young people by domestic violence and child sexual exploitation (CSE). Risk to a young person had been appropriately assessed, recorded and reported to police and children's social care.

Case Example: *A young female receiving support from CAMHS disclosed that she was in a relationship with a male who could be controlling and abusive and further that there had been an incident of violence that had been reported to police. The incident was minimised by the young person.*

Further disclosure indicated her inappropriate communications with a male known to police as being a risk to children and young people. It was recognised by the CAMHS practitioner that the young person's mental health diagnosis placed her at increased risk.

A discussion took place between the young person and the practitioner regarding the recognised risks. Initially she was reluctant for a referral to be made to the MARAC regarding domestic violence and to children's social care regarding the perceived risk of CSE. However, with further discussion, the practitioner was able to impress upon her the importance of the referrals being made in order to protect her from harm and she gave consent for the referrals to be made.

The client records demonstrated that risk to the young person had been appropriately assessed, recorded and reported to partner agencies.

- 2.12 There is an effective pathway in place for the transition of young people from CAMHS into adult mental health services set out in an established policy. In more complex cases the transition process is initiated early and routinely involves joint meetings taking place between the young person, CAMHS practitioners and adult mental health practitioners. Children and young people living with learning disabilities are provided with a health passport on transitioning into the adult service. Young people tell us of the importance of being well prepared and engaged with the transition into adult services which can often seem to be very different from children's services in the way that they are provided.
- 2.13 We were told that adult mental health practitioners would try to "think family" while working with the adult and we did see some case examples where practitioners had responded promptly when concerns about child safety were identified. We also saw evidence of some good information sharing between adult mental health staff and health visitors. However there are a number of key areas for development in the service to raise the standard of child safeguarding practice. Children are not immediately identifiable within case records on client demographic details and they were often hard to find in the record even when we knew there were children in the family (**Recommendation 1.6**).

- 2.14 Risk assessments we were told, are completed as part of the initial assessment process and at other times when indicated; if circumstances change, or as part of a planned review, although we did not see case evidence for this. Risk assessments seen did not demonstrate sufficient consideration of the impact of parental mental health on the wellbeing of children, particularly when mental health was deteriorating. The main consideration of the presence of children was in how, in mental health terms, they represented a “protective factor” in reducing the parental risk of self-harm. There was insufficient consideration in what were the child protection issues in relation to safeguarding the child (**Recommendation 1.7**).
- 2.15 There was no awareness or use of flagging on the electronic record system and the service managers were unable to identify the cohort of children within caseloads and which of these may be subject to CIN or child protection status. As a consequence, there is no facility for managers to monitor the safeguarding of children by practitioners (**Recommendations 1.6 and 1.8**).
- 2.16 We saw excellent and well evidenced Think Family practice in CADAS. There is an assessment form in use which includes mandatory fields for details of children including; parental status, if there are children living at home, children living with relatives or in local authority care. There are questions about the numbers of children in the family and if there is a CIN or child protection plan in place. This ensures that the location and welfare of children is updated and central to the on-going plan of work. The highly robust graduated risk assessment is red/amber/green (RAG) rated so that a client may not have children but still be identified as posing potential risk to them. Records also included alerts for registered sex offenders. Some of the processes and practice seen in this service is exemplary, subject to very robust operational governance and could be used to model improvements needed in adult mental health which is now provided by the same trust.
- 2.17 We were told that the interface between CADAS and adult mental health services is variable. A dual diagnosis pathway has just been introduced by the trust. The presence of mental health difficulties and addictions is a high risk factor in the safeguarding of children. Although too early to comment on the effectiveness, the development of a pathway to strengthen and clarify this complex area of practice is positive.

2.18 GPs hold regular, monthly vulnerable families meetings with health visitors to discuss child safeguarding. Individual cases are discussed at those meetings and relevant information shared helping to identify vulnerability early and facilitate the provision of early support. One practice identified over 80 families which are routinely monitored for risk. School nurses do attend such meetings on occasion but this is not routine. One practice maintained telephone liaison with the school nurse service. Some practices also have regular attendance by adult substance misuse practitioners and midwives, although this was also reported to be variable. In one practice visited, we were told how the meetings take place on a secure video link with another satellite practice some distance away and that children and young people who do not currently meet the criteria for child protection measures are also discussed. All children and young people discussed are allocated an individual GP to oversee their case. This is excellent practice.

Good practice in Primary Care: *One GP practice inspected has developed a 'keeping patients safe' template. This is available to all practice staff and contains safeguarding advice and guidance and links to other resources, including documentation used to make referrals to social care, a link to the inter-agency referral form, a link to Gillick competency and Fraser guidelines and recognising signs and symptoms of abuse and neglect.*

This demonstrates pro-active work on the part of the individual practice to ensure all staff members are aware of their responsibilities in safeguarding vulnerable young people.

Learning from a serious case review has led to the same GP practice revising how vulnerable people are highlighted using the patient electronic record, SystmOne.

A bold new window on the electronic record will alert the practitioner to consider all safeguarding aspects prior to prescribing contraceptives to potentially vulnerable young people.

Likewise, if a child or young person is subject to a child protection plan; is a child in need or is a looked after child then another bold advisory window will appear to notify the practitioner. The pop-up window is an excellent prompt and much clearer than the usual flags which could be missed.

This piece of work took the lead GP approximately three hours to develop and install using available resources over and above the patient flagging system already in use on SystmOne. Visually, it is much more evident to practitioners accessing patient records that due consideration should be given to the vulnerabilities of the particular patient or their children and that their interactions and the practitioner's decision making process should be recorded accordingly.

This has the potential to be used as an exemplar to model good practice in order to strengthen GP safeguarding risk assessment across primary care in Dorset.

Case Example: *A GP was visited by a young mother who disclosed she was in a relationship with a male who was abusing drugs. A discussion took place during which the GP raised concerns for the young person living with them. The family were not known to social services and the GP advised the mother that a referral would be made to social services. The mother agreed with the course of action although hesitantly.*

The lead safeguarding GP reported the information to an adult substance misuse worker who held regular clinics at the surgery. They were unaware of the male using illegal substances and decided to confront him with the information. Health visiting services were also informed and appropriate 'flags' were placed on all the family's patient records.

The result has been increased health visitor and adult substance misuse interventions with the family to reduce risk to all. The family are discussed at practice safeguarding meetings and social care are not currently involved due to the level of support already in place operative as an effective Team Around the Family (TAF).

- 2.19 GUM and CASH services provided by both Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust also demonstrated learning and progressive improvements in safeguarding practice. An example being; the introduction of follow-up appointments for vulnerable young people and being pro-active in chasing up if the young person does not attend.
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3. Child protection

- 3.1 The quality of referrals to children's social care we have seen across most services is variable. In CAMHS however, referrals seen were detailed, articulated risk to the young person well and included information about the child's family and siblings likely to be useful to children's social care in planning their response.
- 3.2 Although in other services, all referrals shared information to a greater or lesser extent, the analysis and articulation of risk of harm to the unborn, new-born, child or young person varied in clarity. In some examples there was a lack of clarity about how a parent's risky behaviours could cause harm to the unborn or child. The expected response or outcome of the referral was not routinely identified or documented and in some examples, particularly where referrals were made in the form of a letter such as we saw in adult mental health, it was not clear whether it was intended as a referral or simply to share information with children's social care. This does not facilitate effective decision making in children's social care about how best to support the needs of the family or assess risks to the child. While there has been some auditing of referrals by the provider safeguarding teams, which also identified a range of quality; routine quality assurance by operational managers and safeguarding leads across provider services is underdeveloped (**Recommendations 1.9 and 2.9**). *This issue has been drawn to the attention of Public Health Dorset as the commissioner of health visitor, sexual health and school nurse services.*
- 3.3 In adult mental health, we saw a case where information was passed to the health visitor to make the referral whereas there were clear indicators which should have prompted the mental health practitioners to make the referral themselves. Delay in making referrals to safeguarding or passing the responsibility to another service provider is a common feature of serious case reviews and is poor practice. (**Recommendation 1.10**).

- 3.4 At Dorset County hospital midwives attendance at pre-birth safeguarding meetings is prioritised and practitioners are present, provide a report if needed, and feedback to the lead midwife safeguarding children. Although attendance is not formally monitored or audited, in cases reviewed we did see good evidence of the outcomes of safeguarding meetings being appropriately recorded in patients notes. This ensures the wider obstetric and maternity team is fully aware of the most up to date safeguarding information and plan. However minutes of safeguarding meetings ICPCs, core groups and review case conferences are not routinely placed in patient's notes. This means that a large section of essential safeguarding information is missing and that the patient's notes are incomplete **(Recommendation 2.10)**.
- 3.5 A pan-Dorset/multi-agency female genital mutilation (FGM) policy is being developed but this is not yet in place. A question is included in the midwifery social history form which should be completed at booking. However this is not monitored or audited and we also found that although CSE is included in midwifery training, consideration of the potential for the expectant woman to be a victim of exploitation could be better evidenced in practice **(Recommendation 2.11)**.
- 3.6 Compliance with the safeguarding assessment proforma within the paediatric notes at Dorset County Hospital is good. This assessment is based on NICE guidance but also refers clinicians to an "indicators of concern matrix" which aims to aid professional analysis of risk and provides a guide to appropriate actions to take in response to any identified risk
- 3.7 GUM has responded appropriately and promptly to safeguard very young girls, making immediate referrals to children's social care, providing reports to inform child protection case conferences, and liaising with other involved professionals

Case Example: One case we tracked across several services showed the value of effective local information sharing and the GP practices' monthly multi-disciplinary liaison meetings.

As a result of the circumstances of a 13 year old girl's attendance at a MIU, a safeguarding referral was made to children's social care. The MIU contacted the GP practice and the progress of the referral was closely monitored by the GP. The GP also made direct contact with the social worker to discuss concerns.

The GP and other health professionals were concerned that the referral was not being actioned promptly and having considered all the known information, the case was escalated to the designated safeguarding nurse and then to management within children's services. A full assessment was then started and child protection arrangements initiated.

- 3.8 In the school nurse service, where reports are submitted to child protection conferences in cases reviewed, the practitioner set out what was working well and what needed to change. However, in one report for a review case conference the template used was not the current proforma. Case records of conference reports did not always demonstrate well that risks or impact of parental behaviour or family circumstance on the child had been fully analysed or considered however. In one case, following de-escalation of a case from Section 47 to CIN, we did not see any pro-active professional challenge from the school nurse despite significant health concerns recorded in the record. It is essential that where professional differences arise in child protection cases, these can be raised with confidence by practitioners and resolved in order that the professionals in the conference reach the optimum decision that will best protect and support the child.
- 3.9 The school nurse service is commissioned to deliver services including immunisations to those missing from education and those home schooled. Currently there is no robust system in place to identify this group of vulnerable children and young people. As a consequence there may be children and young people with unmet health and wellbeing needs in Dorset. An absence of effective professional oversight of the needs of home educated children has been a feature of serious case reviews (SCRs). *Issues identified in paragraphs 3.8 and 3.9 have been drawn to the attention of Dorset County Council children's social care and Public Health Dorset as the commissioner of the school nurse service and also be drawn to the attention of NHS England as commissioner of the immunisation service described.*

Case Example: *The school nurse service is currently commissioned to provide immunisations to those children and young people attending independent schools and also provides a service to children and young people in independent schools although the offer may be different to that provided to main stream schools.*

The young person in this case example was subject to a child protection plan. A report from the paediatrician in September 2014 outlined needs for the child as

- 1. Learning difficulties.*
- 2. OCD / anxiety – for CAMHS support*
- 3. Language difficulties - awaiting speech therapy*
- 4. Fine motor co-ordination.*

There was no identified role for the school nurse and at the review case conference they sent apologies but submitted a report detailing that they did not have any involvement. At this point the child had moved to an independent school.

In the case record on SystmOne we were able to see that the GP was maintaining some oversight as they were recording this in the safeguarding node. We were not able to access any other part of the GP record however, as it had not been shared.

There was no clear exit process in place for the child who remained subject to a child protection plan as the child moved from the offer of receiving care from the school nurse to not receiving school nurse support having moved to an independent school.

There was no communication by the school nurse with the GP or CAMHS to inform them of exit from the school nurse service and that there would be no further school nurse oversight.

Whilst there was no identified role for the school nurse more robust inter-professional communication may have alerted the GP and CAMHS to determine clearly how the health component to child protection processes was to be maintained and to ensure an on-going oversight of the child's health needs.

- 3.10 CAMHS have a did not attend (DNA) policy in place which dictates that if a child or young person does not attend for a planned meeting on three separate occasions then the case will be discussed and any safeguarding concerns raised and social care will be informed accordingly.

- 3.11 The CAMHS social worker routinely provides detailed and comprehensive reports to inform initial and review child protection and child in need case conferences. Reports examined clearly articulated risk and presented individual and family information which inform the child protection process and decision making well. Use of an agreed template for reports to conference helps to ensure consistency of information and facilitates effective quality assurance by managers.
- 3.12 CAMHS practitioners told us that difficulties in receiving timely invitations from children's social care to attend child protection case conferences have been discussed by the partner agencies and recently, the invitation pathway is working more effectively. Minutes from child protection meetings are routinely received by CAMHS and we saw that these are uploaded to client records and, where appropriate, they go on to inform the care planning process.
- 3.13 Health providers, including primary care, are well engaged with multi-agency risk assessment conferences (MARAC) processes which focus on families where there is known to be significant domestic violence. GPs visited were aware of the MARAC process and would make referrals to it when required. One GP surgery had a domestic violence lead who has attended training on the subject and cascades knowledge to other staff members.
- 3.14 Adult mental health managers have a clear expectation that adult mental health practitioners will attend child protection case conferences and participate in core groups. They also were clear that they expect practitioners to submit written reports in advance of conference. However, case sampling demonstrated that practitioners are not always compliant with that expectation and there is no process in place whereby compliance with service expectation is monitored (**Recommendation 1.8**).
- 3.15 We saw some good child protection practice in primary care although there was scope to further strengthen GP participation in conferences and ensuring the outcomes of conferences or CIN reviews are recorded. GPs respond promptly to request for reports for child protection case conferences although they told us they often receive late notifications for the dates of conferences. Review conferences are planned six months ahead and some GPs were not aware that the minutes of the previous conference contain the date of the next planned conference. GP practices do have time to plan their participation even where attendance is not possible. This could take place through blocking some appointment space and teleconferencing or Skyping into the conference. Alternative ways of participation in child protection processes by GPs has not been explored. Outcomes of child protection case conferences and CIN meetings were not always identifiable in records, meaning that some GPs were unaware of the latest status of some children or where there were plans with health implications (**Recommendation 3.1**).

Case Example 1: *A teenage Asian female became pregnant by her Caucasian boyfriend. When she became pregnant, it was determined that she was at risk of honour-based violence.*

All agencies worked together to try to protect her as she was unwilling to move away and initially didn't believe the extent of the personal risk although the police were very concerned.

The GP and midwife arranged for her to be seen at a satellite GP site and close confidentiality was maintained by all professionals. The GPs patient record was flagged as "at risk of violence" and receptionists prevented information about the young person being disclosed.

Case Example 2: *A family with two children aged 14 and nine on child protection plans for emotional abuse. The children's father had a history of domestic violence and substance misuse and was no longer with the family. The children's mother had some history of alcohol misuse.*

The GP identified the family as part of their multi-disciplinary vulnerable families meeting cohort and all family members were flagged on SystemOne as child protection cases.

The GP noticed that a new male adult registered at the property; checked records and identified that the male had a history with youth offending services as an inmate where ADHD had been diagnosed as well as a history of substance misuse.

The GP alerted children's social care about this new male in the household who potentially posed risks to children already subject to child protection plans.

4. Looked after children

- 4.1 There is a large cohort of looked-after children in Dorset. There were 437 children in the care of the local authority at the time of this inspection with approximately 80 children placed outside the authority area. In April 2015, compliance with expected timescale for initial health assessments (IHAs) was at 7%. Compliance for IHAs in September was 19%; this is of significant concern. Children and young people coming into care in Dorset are likely to experience significant delay in having their health needs assessed and this adds to their level of vulnerability (**Recommendation 1.11**).
- 4.2 All IHAs are undertaken by appropriately qualified paediatricians with oversight from the designated doctor for looked-after children. The designated doctor will undertake the IHAs for children placed out of area if the child can be brought back into Dorset. Most IHAs are undertaken in Poole following a recent change in provider arrangements. This is causing significant inconvenience for foster carers.
- 4.3 Birth parents are invited to attend health assessments and there is a drive to capture health history from birth parents regardless of the plan for the child. If parents do not attend the medical the designated doctor will call them to try and get information for the IHA. This is important, as young people tell us that a lack of parental health history can have long term detrimental effects as they enter adulthood. There was also an absence of the legal status and why the child had become looked-after in a number of cases reviewed. This information can only be obtained at the point the child comes into care and it is beholden on social care and health practitioners to make every effort to ensure that information goes with the child on their journey through care (**Recommendation 1.11**).
- 4.4 We saw little evidence of consent to the assessment being obtained from the young person. This is a missed opportunity to encourage the young person to engage with their health care (**Recommendation 1.12**).
- 4.5 We were told that all medical advisors have received additional training in respect of CSE and FGM and use the CSE risk assessment pro-forma. Evidence of its use was not seen in the cases we sampled however.

- 4.6 If young people refuse the initial health assessment then the agreed process is that the paediatrician will refer to the specialist LAC nurse for early contact and review. However, capacity issues are creating significant backlogs of work so there is a risk of further delay and drift with children not having their health needs addressed. The IHA triggers the due date for the review health assessment (RHAs) but if young people haven't attended for the IHA then there is no established or effective system of follow through to ensure the young person is picked up by the specialist nurse **(Recommendation 1.13)**.
- 4.7 We were told that although health visitors routinely undertake the RHAs for under 5s, practitioners need more training to raise the overall standard. RHAs we reviewed for under 5s were at times scant in details and the resultant health plans were not always SMART. **(Recommendation 1.14)**. *This issue was drawn to the attention of Public Health Dorset as the commissioner of the health visitor service.*
- 4.8 The designated looked-after children's nurse audits and quality assures review health assessments (RHAs) periodically. We were told that the specialist looked-after children's nurses were using a national tool to quality assure RHAs and that this is being further enhanced by the introduction of a new quality assurance tool, developed by the designated looked-after children's nurse. Training on the use of this tool is being delivered to the specialist nurses. However, there was no evidence of effective quality assurance of RHAs happening in day to day practice and given the capacity pressures within the service; we could not be assured that this was actually happening **(Recommendation 1.15)**.
- 4.9 Currently, the specialist looked-after child nurses have the responsibility to undertake the review health assessments for school age children and young people. The specialist looked-after children nurses are flexible about meeting young people in the evenings and there is a high level of commitment from the specialist practitioners to the process being young person centred and led.

Case Example: *A young person living in a residential home was self-harming frequently, resulting in being taken by ambulance to the local ED. CAMHS were involved with the young person. The young person's CAMHS practitioner, the specialist looked-after child nurse, paramedic service and the manager of the residential home met with the young person's GP, at the GP practice, to discuss and agree a multi-disciplinary plan to support the child and sustain the residential placement.*

It was agreed that the paramedics, if called out to the young person, would maintain a low profile, without any siren or flashing lights treat the young person in situ when possible although take to the ED if necessary. This reduced the profile of the events and was sensitive to the needs of the young person concerned as well as the remaining cohort of young people in the home.

As a result of this effective multi-disciplinary approach;

- there was a reduction in the young person self-harming*
- the young person's unwanted behaviours reduced*
- there was a reduction in stress and tension within the cohort of young people in the residential home*

- 4.10 The current operating model of the specialist looked-after child nurses undertaking the RHAs for the older children is laudable on the one hand, as these children would have the input and engagement of specialist practitioners if the model was operating effectively. However, due to the high numbers of looked-after children and limited capacity of the specialist team, the system is failing. For quarter two there was a drop in the timeliness of RHAs to 50%. Specialist looked-after child nurse practitioners told us that they are playing catch-up and that they do not have the capacity to reduce the backlog of outstanding health reviews. This is placing the practitioners under significant pressure to the potential detriment of their wellbeing (**Recommendation 1.16**).

Case Example: *A 16 year old female who has been looked after for five years. She has always engaged well with her health reviews which have been undertaken for four years by one of the specialist looked-after children's nurses. A positive relationship had been developed between the young person and the specialist looked-after child nurse over this period.*

Due to the current capacity pressures, school nurses have been undertaking some health reviews and this year the young person was offered a review of her health needs from a school nurse. The young person declined to have her health needs reviewed.

It was not clear what steps would be taken to try to re-engage the young person with regular reviews of her health.

Case Example: *In some cases reviewed, support being given to the looked-after child specialist health team by the school nurse service has resulted in some positive outcomes and continuity for the child.*

In one case, the school nurse had contributed significantly to the multi-agency safeguarding process which resulted in the child and siblings being taken into care as a consequence of significant neglect. We saw good use of the case record by the school nurse practitioner in capturing the journey of the child through escalating and de-escalating concerns..

The child, around the time of being placed into care, was assessed and had very delayed speech and language. The school nurse undertook the review assessment and found that the child had responded well to support from the foster carers and professionals. There was a significant improvement in the child's speech and language skills in addition to other improved outcomes.

Unfortunately we were not able to see the completed health assessment to underpin this as, there had been a delay in the assessment documentation being uploaded onto the child's record at the time of this inspection in November.

- 4.11 We were told that school nurses are currently supporting the LAC Health team in undertaking review health assessments to help achieve timescales. This has provided some positive continuity of care for some looked-after children. However school nurses told us that they have not received any recent training or updates to support them to achieve any benchmarked standard that may be expected in completing health reviews (**Recommendation 1.14**). This issue has been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.

- 4.12 The LAC administration team inform school health of children coming into care as part of the IHA process. The letter specifically asks school health to update their system however, it was not clear to us that information sharing systems operating for looked-after children were working effectively. At the time of this inspection the provider was progressing with implementation of SystmOne for the LAC service. This will enable the health visitor, school nurse and LAC patient record system to be the same and should facilitate electronic sharing of information. At the time of this inspection, school nurses did not have an oversight of the overall cohort of LAC in the 5-19 population or held in universal school nurse caseloads. Joint guidance from the Department of Health (DH), NHS England in partnership with Directors of Public Health and the Local Government Association (2014) highlighted the need for the local authority commissioner, NHS England commissioner and providers to work closely to support high uptake of the vaccination programme in the 5-19 population. This gap is preventing the school nurse service from delivering an equitable service across Dorset and may impact on looked-after children's health outcomes (**Recommendation 4.2**). *Issues set out in paragraphs 4.11 and 4.12 have been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.*
- 4.13 We found significant delay in scanning or uploading RHAs into the case record in school nursing, in the specialist looked-after children's health team and in the children's social care record system. This results in high risk that a child's health needs will not be met promptly and increases the likelihood of drift, detrimental to the child's health and wellbeing. We saw a number of cases which demonstrated the potential for drift as a result of poor recording and operational governance across the health and social care partnership. *This issue has been drawn to the attention of Dorset County Council who employ the specialist looked-after child health team administrators and to Public Health Dorset as the commissioner of the school nurse service.*
- 4.14 In school nursing, we were told that it is routine practice not to upload part B of the documentation onto the child's record. This results in an incomplete record of the detail of the assessment which underpins the health summary and resultant health plan. It undermines any opportunity for robust quality assurance by operational managers in the healthcare trust's specialist looked-after children's health team. Health plans seen in school nursing identified appropriate actions but lacked a SMART approach. The action plan in one case missed opportunities to include more of a public health focus to help maintain optimum health. For example; healthy eating, physical activity, oral health and emotional wellbeing. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.*

- 4.15 There does not appear to be an agreed pathway to identify which health team (LAC or school nurse) are responsible for reviewing the impact of health action plans completed by school nurses while the school nurse service is temporarily undertaking RHAs to support the looked-after children's health team. There is a risk that health needs and actions may not be reviewed until a statutory LAC review or the following year at the next health assessment. We were told that a new format for health plans was being introduced to include what actions have been taken and the date on which actions were completed but we did not see evidence of its use in the cases we reviewed. If a child or young person leaves the care system, there is not a clear and robust pathway to ensure that identified health needs are followed up in primary care, health visitor or school nurse services **(Recommendation 1.17)**. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of the health visitor and school nurse service.*
- 4.16 Prior to the young person's RHA, a pre-health assessment, which ideally includes the completion of the strengths and difficulties questionnaire (SDQ) is undertaken by the young person, where appropriate, and the foster carer. This helps to inform the RHA and ensure any emotional health concerns indicated by the SDQ are promptly referred to the specialist CAMHS looked-after child psychologist. A post assessment questionnaire is also sent out to seek feedback. We were told that feedback the service receives from these is positive.
- 4.17 CAMHS practitioners told us that they are regularly asked to provide information to inform the initial and review health assessment process. The looked-after child health practitioners have access to CAMHS client records on a 'read only' basis when those young people are subject to CAMHS service therapeutic input. This supports effective information sharing and should ensure that important information about the child's CAMHS engagement can inform the annual health review. Information is not routinely sought from the child's GP to inform the review health assessment however and this is a gap **(Recommendations 1.18 and 3.2)**.
- 4.18 CAMHS services in Dorset benefit from the provision of a dedicated social worker within the team. This is particularly important in the work that is undertaken by the social worker in conjunction with the CAMHS clinical psychologist with families and foster carers to reduce the risk of placement breakdown. Foster carers are supported well by CAMHS practitioners, the CAMHS social worker and the clinical psychologist through support and advice as well as the offer of a 12 week course regarding attachment, reflection and understanding the specific needs of looked after children. We saw good outcomes for looked-after children as a result of the work to support fragile placements.

- 4.19 Looked after children with emotional health problems are prioritised for CAMHS assessment following referral. All looked-after child referrals are assessed by the CAMHS social worker to identify the appropriate pathway; these can include individual therapy, family work, attachment and group work.
- 4.20 In one GP practice the vulnerable families meeting included looked-after children. In another practice, a six monthly looked after children's meeting takes place. All looked after children registered at the surgery are discussed in order that the practice can best understand and meet the health needs of this vulnerable cohort. This is exemplary practice. In both practices the GPs are highly aware of the potential additional needs of children who are in care although we are aware that this may not be true of all GP practices.
- 4.21 Understanding of the particular vulnerabilities of looked-after children and young people is not high in the GUM and CASH services provided by both trusts and we saw case evidence where a greater understanding of the needs of this cohort and liaison with the specialist looked-after children's nurse team would have been beneficial.
- 4.22 Young people we spoke with who are currently in care were not aware what health information they will be given when they leave care but all agreed they would like as much information as possible. All of the young people we spoke with agreed that they are not provided with information about what support is available to them and if they want anything they have to ask what is available or research it themselves.
- 4.23 The CAMHS clinical psychologist undertakes psycho-education therapy with young people who are looked after from age 16 to help them better understand their mental health background, the reasons for any self-harming behaviours, anxiety and how to access services when an adult.
- 4.24 Although commissioned only to support looked-after children up to the age of 18 years, the specialist looked-after child nurses will provide support beyond this to individual young people on request by the leaving care team, subject to capacity. Work has been ongoing to improve the health support offer to care leavers. A recently introduced health passport has been co-produced with young people in care. This gives the young person information on how to access local core health services such as registering with a GP and dentist and local sexual health services. This is a well-produced and concise health record document which can be developed and populated in a very personal way as the child moves through adolescence towards leaving care. Unfortunately, we did not meet any young people this week who had been provided with the passport but we recognise that it is a recent introduction.

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 Phase one of the multi-agency safeguarding hub (MASH) has been operational since July 2015 in the form of a multi-agency information sharing team (MAIST). Partners from police, children's social care and health are co-located within Poole police station and have been sharing multiagency information in regards to all of the domestic violence forms (SCARF) received. This is positive evidence of good partnership working. Strategic discussions are now being held with the partner agencies, regarding phase two of the MASH, which may lead onto the development of a fully functioning MASH, to include referrals to children's social care. However, this is dependent upon agreement with all three local authorities, who currently all have different levels of input into the MASH. There is currently no specific timeframe for the future development of the MASH. Dorset County Council has agreed to have a decision maker within the arrangements and a principal social worker has taken on the lead role in taking forward the local authority's engagement in the development of the MASH.
- 5.1.2 A health and social care jointly commissioned child sexual exploitation/missing children service provided by Barnardo's has been operational from October 2015. The service is based within the police missing persons unit and provides a service to young people identified as at risk of CSE. Contract monitoring meetings are in place, which the CCG attend.
- 5.1.3 NHS England (Central) re-commissioned the sexual assault referral centre (SARC) service earlier in 2015. The new service includes a nurse led forensic service. NHS England (Central) has also commissioned a health needs analysis to inform the re-commissioned paediatric component of the SARC. This is expected to see all examinations of children aged under 16 to be completed by a competent paediatrician and is a positive development.

- 5.1.4 Health agencies are well engaged with the Dorset safeguarding board arrangements (DSCB). NHS Dorset CCG, Dorset Healthcare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust all achieved 100% attendance in the last two years, as has the designated doctor and designated nurse consultant for safeguarding. The director for quality and designated nurse continue to represent the CCG at the two LSCBs and various sub groups. Although previously considered and championed by both the NHS and police, there are currently no plans to develop a pan-Dorset LSCB.
- 5.1.5 The CCG's provision of a dedicated designated looked-after children's nurse role is positive; giving good focus to an area with a significant improvement agenda. The role facilitates the development of an effective three way partnership between health commissioners, social care and the health provider and the establishment of a robust performance management framework. However, it is essential that all agencies take ownership and work together to effect real change (**Recommendation 1.11**).
- 5.1.6 The NHS England Wessex area team and Dorset CCG are currently exploring the practicalities of how primary care can demonstrate that it is Section 11 compliant. The Local Medical Committee (LMC) is being consulted as to how this will be progressed. We did find that there is more for the Wessex area team, the CCG and Dorset Healthcare University NHS Foundation Trust to do working with primary care to ensure that GPs develop their vulnerable families meetings to routinely involve midwives, health visitors, school nurses, adult mental health and substance misuse workers (**Recommendation 4.1**). *This area for development has also been drawn to the attention of Public Health Dorset as the commissioner of health visitor, school nurses and adult substance misuse services.*
- 5.1.7 The designated professionals for safeguarding work well together and with the named GPs to give positive leadership across the health economy. The designated nurse is supporting Dorset social care in reviewing complex cases of children on the cusp of entering care. The designated doctor provides supervision and development to the named GPs. She also works to support the LSCB by being involved in the development of clinical pathways for the pan-Dorset safeguarding procedures, reviewing cases of concern including fabricated and induced illness (FII) and offering advice and support to multi-agency partners.

- 5.1.8 There are currently two named GPs and a third is being recruited. The named doctors' remit encompasses adult and children's safeguarding which gives a good oversight across the child's journey and the named doctors are developing their leadership profile. Dorset has received additional funding from the Wessex Area Team for an increase of four sessions to the named GP role and the recruitment of a third named GP will strengthen leadership across primary care. There is a primary care safeguarding leads forum which has just been introduced, having had one meeting so far. The recent introduction of this forum is a positive development. It gives a good opportunity for GPs to share good practice and develop knowledge and expertise as well as raise the profile of the role of the named GPs, as not all GPs we met were aware of them or their role. The named GPs have made positive use of the GP safeguarding toolkit and from this have developed a local toolkit to support the improvement of safeguarding practice across primary care. Supervision for GPs is also beginning to be introduced. A "Lunch and Learn" pack for primary care administrative staff has been introduced, delivered by the LMC and similar sessions for GPs are being developed.
- 5.1.9 GPs spoken with told us that they can access advice and guidance from named GPs as and when required. GPs are well supported by the designated nurse although awareness of the named GPs varied. Some GPs identified a gap in keeping them updated in relation to local and national trends in safeguarding although they do access the LSCB website and share relevant information with practice staff.
- 5.1.10 We saw good leadership on child safeguarding from the lead safeguarding GPs in the four practices that we visited and all were proactively monitoring and developing safeguarding practice in their teams. One safeguarding lead GP we met was new in post but was enthusiastic about the role; had already audited MIU attendances and DNA's at the surgery and practice has changed as a result of this.
- 5.1.11 The named nurses and named professionals across provider services are well regarded and accessible to staff for advice and guidance. We saw good evidence that the presence of knowledgeable, confident and authoritative safeguarding advisors from the health care trust in the developing MAIST is becoming increasingly valued by Police and social care.
- 5.1.12 Dorset County Hospital NHS Foundation Trust took prompt remedial action to respond to the findings of this review in relation to the ED. The trust implemented immediate overrides to the IT system during the inspection to ensure all under 18 year-olds attending ED are immediately identifiable by clinicians as children and put in place an action plan to implement improvements and increase dedicated paediatric liaison hours to strengthen safeguarding governance.

- 5.1.13 In adult mental health there is no formal Think Family approach and the service is not being overtly developed to deliver a Think Family service delivery model. There is a lack of managerial oversight within the service to monitor practitioner child safeguarding practice as demonstrated through the case record. Managers in the service operate under the assumption that experienced clinicians will identify concerns, take appropriate action and make good quality referrals. Case evidence we reviewed did not always bear this out. The establishment of effective operational governance and quality assurance supports practitioners in delivering best safeguarding practice and facilitates continuous professional development. The absence of this in adult mental health is a gap which raises risk that children and young people may not be safeguarded effectively (**Recommendation 1.8**).
- 5.1.14 Access to specialist perinatal mental health treatment and support is inequitable as the specialist service does not operate in West Dorset and is therefore not fully compliant with NICE guidance. We were informed that the CCG recently led a multi-agency group to redevelop the perinatal mental health pathway; implementation of this has been delayed due to the need to re-contract the specialist service but is expected to start in Spring 2016. The new service will be provided pan-Dorset (**Recommendation 5.1**).
- 5.1.15 Dorset's CSE strategic and operational planning and risk identification arrangements (RIMs) do not currently include direct representation from sexual health services, rather representation is through the safeguarding advisors and named nurse. We increasingly see full participation in CSE risk panel arrangements by sexual health services as they can be key information holders about young people at risk of exploitation which can strengthen panel discussions and outcomes. Reconsideration of the arrangements would be timely. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of sexual health services.*
- 5.1.16 Monthly locality meetings are well facilitated by health visitor team leaders to bring staff up to date with any new developments or current issues. This system ensures a good flow of information across teams and enables health visitors to be informed of any new issues or developments that may affect their practice.
- 5.1.17 The health visitor service is experiencing capacity pressures although fully staffed. We were told that caseloads are heavy and the situation is compounded by rurality impacting upon travel time. We understand that difficulties in recruitment and capacity to train new health visitors from the Call to Action programme resulted in the service not meeting its target by 10 whole time equivalent health visitors within the timeframes for funding. Practitioners are concerned that in the northern part of Dorset there are plans to build 1000 new houses and this will impact further on capacity of the health visiting teams. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of the health visitor service.*

- 5.1.18 In CAMHS, the young person's consent is routinely sought and recorded in client records. Consent forms are signed by the young person and then scanned onto the client record. In one record, we saw that the young person was transitioning to adult services: their consent was checked and received so that their records from CAMHS could be shared with adult service practitioners prior to the transition. This is good practice, particularly as part of the transition pathway into the adult mental health service, as young people tell us that it is important for them to understand what it is that they are consenting to in relation to information sharing.
- 5.1.19 Following a skills audit in Dorset's CAMHS, there is now equitable access to CAMHS services across the county with each team now being able to provide the same services to young people. Information pertaining to what services are offered by CAMHS has been provided to all lead GP s in individual practices electronically, in order to help GPs target referrals appropriately. However, CAMHS practitioners told us that referrals into their service, especially from GPs are variable in quality; not routinely setting out the reasons for the referral and the number of referrals from GPs for services that CAMHS do not provide remains high.
- 5.1.20 The GUM and CASH services operated by both Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust have established appropriate safeguarding leadership arrangements. The risks arising from the lack of a robust, service wide management information system for GUM and CASH services have been recognised but as a result of the suspension of recommissioning there has been no progress on developing more effective IT systems. This presents a barrier to effective safeguarding work and identification of risks. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of sexual health services.*
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5.2 Governance

- 5.2.1 Performance on timeliness of IHA and RHAs is unacceptably poor and requires urgent attention across the partnership. Forums set up across the partnership of children's social care, the CCG and the provider trusts have not been effective in driving up performance to date. Children's social care has had an improvement plan for looked-after children for the past year but there is no evidence of improvement resulting from this. Notifications and documentation is routinely slow to come through from children's social care practitioners. This presents additional challenges to a looked-after children's health system already under pressure and is contributing significantly to the very low level of performance. There is a high likelihood that children and young people are entering and leaving the care system without having had an assessment of their health needs, this adds to their already high level of vulnerability and is unacceptable.

- 5.2.2 Senior managers across the partnership acknowledged the findings of this inspection in relation to looked-after children's healthcare and a joint working group is being established to meet monthly. This will involve the designated doctor for looked-after children, a senior manager from the local authority and the healthcare trust. This group will report to a meeting between the designated nurse for looked-after children and the local authority commissioner to oversee improvement (**Recommendation 1.11**).
- 5.2.3 We saw little evidence of the healthcare trust having effective operational management and oversight of the delivery of health support to looked-after children at the frontline. CCG governance arrangements in relation to the delivery of effective healthcare for looked-after children were not evidence-based nor sufficiently robust. There is a lack of an effective single health database to facilitate effective governance within the health provider and managers and specialist nurses are over-reliant on children's social care data. There was a backlog of RHAs numbering approximately 50 cases which were overdue, some very significantly. We found that children's files had not been made up and therefore records were incomplete; lacking the information that would give a complete overview of the child and their personal situation. It was not clear from discussions with trust practitioners or the manager that the Healthcare trust had a plan in place to address the backlog and ensure sustainable delivery. We were advised that a contingency action plan was being put into place at the request of the CCG as a result of this review and saw evidence of this while on site (**Recommendation 1.15**).
- 5.2.4 The designated professionals have developed a safeguarding performance framework which is a set of safeguarding quarterly performance indicators for all Dorset provider NHS Trusts. This will allow for the emergence of specific health data and enable benchmarking and patterns to be identified with a narrative as required. The indicators have also been informed by the repeated learning from serious incidents and near misses. To date there has not been any specific work which has captured the views of children and young people, especially those who are more vulnerable. The CCG and children's social care commissioners are working together to ensure that contracts for children's services will specifically seek the views of children and young people from a variety of backgrounds, including their experiences of the transition process.
- 5.2.5 Dorset has had a number of serious case reviews (SCRs) over recent years and we saw evidence of learning from these being used very positively to improve practice across services. This was particularly evident in primary care where we saw improvements in safeguarding practice across all four surgeries visited as a result of learning from SCRs. One of the key vehicles for disseminating this learning is the *synopsis of learning* which is sent out routinely following any serious incident or SCR to relevant services and is available to all services through the LSCB website. GPs spoke highly of the synopsis' value in setting out findings and points of learning in a succinct and clear way.

- 5.2.6 Dorset Healthcare University NHS Foundation Trust was inspected by the CQC in June 2015 under the ongoing comprehensive mental health inspection programme which included community health services for children, young people and families. Issues were identified in relation to some safeguarding systems and processes not operating effectively in relation to risk assessment for CAMHS services in Weymouth and Portland and in relation to staffing and other issues at MIUs. An action plan to address recommendations from the inspection is in place. We saw evidence of positive progress in some of the services we visited, notably in the MIU at Weymouth. Staff reported changes in management had resulted in improvements and that the new manager was making sweeping changes for the better and there has been a change in culture and practice. The unit is now staffed to capacity with all staff now on substantive contracts. The staff are either paramedics with emergency care training or nurse trained to degree level. All staff have completed paediatric life-saving training (PILS).
- 5.2.7 Management oversight and quality assurance arrangements for safeguarding and risk assessment in the MIUs is insufficient however to assure consistently robust safeguarding practice. At Blandford and Shaftesbury MIUs, although we were told that practitioners check SystmOne and liaise with health visitors and other professionals if they have any concerns, there was no evidence of this on case notes. We were told that if a clear safeguarding issue is identified, they refer to the children's social care local office by a phone call followed by fax of their notes. Such actions would be recorded on SystmOne but with no read coding or copies kept, cases could not be identified. Each practitioner would be responsible for their own action and follow up. Neither unit could identify any child or adult referred and there is no system to track or audit the quality of assessment, safeguarding referrals and follow up contacts made by MIU practitioners. Given that there is often a sole practitioner on duty, this is especially concerning. Senior staff in the MIUs recognised that there should be some method for quality assurance/ audit to assure practice. MIUs keep a daily print of attendances which are maintained in a file and which identify outcomes/admissions. This could be adapted to include an audit trail for safeguarding referrals (**Recommendation 1.4**).
- 5.2.8 Healthcare Trust safeguarding advisors have "read-only" access to SystmOne and other patient record systems. They are unable to record their own involvement for example in supervision or at strategy discussions or child protection forums directly into the child's record and instead record their own separate records into a shared drive with restricted access. There is a risk that a child's record will not be reflective of the involvement of safeguarding advisors. We have seen in other areas that when practitioners have entered their record of safeguarding supervision into the child's SystmOne record they would task the safeguarding advisor to review the action plan and this would be countersigned or commented on by the advisor. Similarly, this also facilitates effective quality assurance of safeguarding referrals and practice through the case record (**Recommendation 1.19**).

- 5.2.9 CPIS is the national child protection information sharing system between emergency departments (EDs) and children's social care. Currently Dorset, involving all three local authorities; Dorset, Poole and Bournemouth, is unable to progress CPIS due to incompatible IT systems in children's social care. As a result, ED staff are unable to access the national spine to gain information on children who present for care or intervention and who may be subject to a protection plan or deemed at risk. This could lead to missed opportunities for information sharing for those at highest risk. We understand that the organisations are working together to resolve the challenges in order to achieve compliance with this keystone national safeguarding policy.
- 5.2.10 The safeguarding lead nurse within Dorset County Hospital NHS Foundation Trust's ED works part time (0.75 wte) and has no protected safeguarding children hours. Due to the clinical demands of the department, her capacity to have effective oversight of safeguarding practices, promote good practice and drive improvements is limited. There is no process in place whereby all under 18s attendances are reviewed as part of a "safety net" system to ensure that at the time of presentation all vulnerabilities have been considered and all appropriate actions taken (**Recommendation 2.12**).
- 5.2.11 There is a clear governance structure and regular meetings ensure safeguarding issues within maternity services are reported appropriately to the Dorset County Hospital NHS Foundation Trust senior management and board. The maternity department is represented at the safeguarding committee meeting. Safeguarding issues and risks are also discussed at the weekly risk management meetings which feed into the clinical governance and quality assurance committee. Departmental clinical governance meetings and weekly maternity forums are also used to discuss safeguarding children issues.
- 5.2.12 The lead midwife for safeguarding children at Dorset County Hospital has good practical oversight of safeguarding cases referred to her by colleagues and the wider multi-agency economy. However, due to her workload and capacity issues she is unable to undertake audits or robust quality assurance to inform practice improvements within the maternity services. This may be resolved in the new-year when her hours are increasing and her caseload management responsibilities cease (**Recommendation 2.13**).

- 5.2.13 GP practices visited had good governance processes in place to ensure that patient records were promptly updated in regards to CIN or child protection status. This ensures that any professional accessing the practice's patient records is made immediately aware of the child's current status. All GP practices visited are proactive in regularly reviewing their internal governance arrangements to facilitate continuous development of safeguarding practice. Many GPs in Dorset use SystmOne, in common with most of the health services provided by the Dorset HealthCare Trust. This is facilitating the development of good multi-agency information sharing practice. However, not all GP practices use this system and of those who do, not all have set permissions for MIUs to view patient records. This undermines the benefit of having a system that facilitates effective information sharing. There are continuing challenges therefore, to the health and social care community in working towards optimum multi-agency information sharing (**Recommendation 3.3**).
- 5.2.14 School nurses have been using SystmOne for over a year. Prior to that paper records were in operation and school nurses can access the paper records if necessary. In the majority of cases seen the significant events template where appropriate, were used effectively and in most cases reviewed, identified risks and vulnerabilities were flagged appropriately. We saw variation in the standard of record keeping in the electronic journal and records for individual children. As noted above, the strength of the voice of the child was inconsistent and generally not strong.
- 5.2.15 Cases sampled in school nursing revealed that the safeguarding node on SystmOne is underutilised. This often does not reflect the changing needs of the child and whether there are escalating or de-escalating safeguarding concerns. We did see some good use by school nurses but this was too variable. However we did see in two cases' sampled that GP's were using the safeguarding node. In one case the remainder of the GP SystmOne record was not open to sharing with school nurses. This means that unless information is inputted into the safeguarding node of the GP record, the school nurse service may be unaware of some pertinent information about a child they may be working with (**Recommendation 3.3**).
- 5.2.16 Managers are reported to be aware of the capacity and resource challenges the school nursing team are encountering and we understand that the difficulties in recruiting to band 6 vacancies has been identified on the trust's risk register. To address capacity pressures, work previously seen as the role of the band 6 is shared in the skill mixed team and may be delegated to band 5 nurses. This could include report writing and attending child protection case conferences. Staff described increasing workforce demands, vacancies, sickness absence and competing priorities. Managers and practitioners were unable to quantify caseloads and workforce complement but acknowledged that they were likely to exceed the Public Health Visitor Association (CPHVA) suggested 1,200 cases. *Issues set out in paragraphs 5.2. 14, 5.2. 15, and 5.2. 16 have been drawn to the attention of Public Health Dorset as the commissioner of the school nurse service.*

5.3 Training and supervision

- 5.3.1 We were advised that midwives at Dorset County Hospital probably fulfil the required learning hours over a three year period; however the total hours undertaken are not currently gathered or recorded. If compliance is measured solely against the one day level three training provided then midwives are not compliant with the intercollegiate document. Dorset County Hospital Trust acknowledges that training compliance is a challenge and there is an action plan in place. Dorset County Hospital NHS Foundation Trust's named nurse has launched the trust's revised level three safeguarding children training. Historically, the trust has worked with the LSCBs to run a multiagency course from the hospital. It is hoped that this will improve the trust's training compliance which will be subject to more formalised review of training compliance brought into contract monitoring by the CCG.
- 5.3.2 All health visitors are trained to level three for safeguarding and this is commensurate with the intercollegiate guidance. Health visitors have attended additional training including CSE, FGM, paediatric first aid and assessing for developmental hip dysplasia. The health visitor team leader also shares responsibility for health visitor education and encourages staff to attend additional training. This was confirmed by practitioners. Access to training ensures continuous professional development and that practice has a strong evidence base.
- 5.3.3 All CAMHS keyworkers are currently trained to level three in safeguarding children. Records seen demonstrated that where refresher training is due this is booked in advance before the recommended three year period expires. In recognition that a higher proportion of children and young people looked after were self-harming than other young people in Dorset, additional training has been provided to CAMHS practitioners to provide appropriate care and support to this vulnerable client group and reduce risk.
- 5.3.4 In the healthcare trust's adult mental health service, the expectation is for practitioners in the specialist perinatal mental health service to undertake multi-agency level three training and this is appropriate. CMHT adult mental health practitioners and managers however, and adult substance misuse practitioners undertake level two safeguarding training in line with the healthcare trust policy. The training is a combined adult and child safeguarding package. This is inadequate to equip these practitioners and service managers to discharge their safeguarding responsibilities effectively and ensure effective operational governance at the frontline and is not compliant with guidance. Case evidence strongly demonstrated that practitioners in the adult services are routinely working with cases requiring level three competency (**Recommendations 1.20 and 1.21**).

- 5.3.5 The school nurse team receive level three safeguarding training. Staff are encouraged to access additional multi-agency training such as CSE, DV, neglect and compliance is reported monthly.
- 5.3.6 GPs understand the expectation that primary care practitioners will undertake level three safeguarding training. The robustness of this varied significantly however. In one practice this had comprised of the full two day LSCB approved multi-agency training course. Additionally, every month the practice closes for an afternoon so that all staff, including GPs, practice nurses and administrative staff, can meet to discuss different issues, this regularly includes best practice in safeguarding vulnerable children. However in another, although the safeguarding lead GP had attended several multi-agency training events to enhance their own safeguarding knowledge, the rest of the surgery's practitioners had only undertaken on-line level three training which falls well short of intercollegiate and *Working Together* guidance. Safeguarding supervision is also not yet established across primary care and we note the work already in hand with the designated professionals and named GPs to take both areas of work forward.
- 5.3.7 The named GPs and CCG safeguarding team, supported by the LMC, put on three learning-at-lunchtime sessions over the summer for primary care. These were well attended and well received, covering learning from recent Dorset SCRs as well as an update on national issues and PREVENT. The lead GPs organised a day of level three training for GP's in September, with over 50 doctors attending. We understand the intention is to continue these twice a year.
- 5.3.8 Female Genital Mutilation (FGM) is a key NHS England priority although FGM is not deemed to be an area of high activity within Dorset, with seven historic cases having been identified in Dorset since April 2014. Key front line staff have received targeted training and support and each health provider has identified champions within maternity and sexual health outreach. A consultant from Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) has offered to act as a lead for this area pan-Dorset to ensure staff are supported and the right care and safeguarding practice is delivered.
- 5.3.9 CADAs practitioners receive regular one-to-one supervision. A pro-forma is used based on the CQC key outcome areas: safe, effective, caring, responsive and well-led. The safe component includes prompts in respect of record keeping and safeguarding adults and children.

- 5.3.10 Structured, regular safeguarding supervision, appropriate to the ED service is not offered to ED staff at Dorset County Hospital, although good quality ad hoc advice and guidance is available from the ED safeguarding leads and trust safeguarding team. Where we have seen regular group supervision and reflective practice sessions established in emergency departments in other areas, ED practitioners have told us how beneficial they find this in supporting the development of safeguarding practice. Caseload holding midwives at Dorset County hospital do not benefit from in depth one-to-one safeguarding supervision sessions which would best support them in discharging their safeguarding responsibilities **(Recommendation 2.14)**.
- 5.3.11 The looked-after children's nurses also are not fully and adequately supported through the provision of individual supervision; this is provided on a quarterly group basis only although practitioners can request 1:1 sessions. Given the high number of cases of vulnerable children on the caseloads of these practitioners and the significant pressures and challenges in the looked-after children's health service currently, these practitioners would be best supported through the provision of dedicated and protected, planned one-to-one supervision. This would be in line with best practice and would facilitate individualised support focused on the needs and competencies of the individual practitioner **(Recommendation 1.22)**.
- 5.3.12 MIU staff receive group supervision provided quarterly by the Healthcare trust's safeguarding team. There is no formal structured one-to-one but it is available if requested as is ad hoc advice. We were told that any ad hoc consultation on cases are recorded in the case notes but this was not evident from the cases sampled.
- 5.3.13 Discussions are currently underway with Public Health to consider the safeguarding supervision needs of health visitors and school nurses post transfer of commissioning to the local authority. In health visiting, group supervision sessions are facilitated quarterly by the safeguarding team and practitioners report that the sessions are beneficial. However there is no structured regular one-to-one safeguarding supervision provided to health visitors although one-to-one supervision can be requested by the practitioner on an ad hoc basis. In the school nurse service, safeguarding supervision is offered formally in group settings three monthly and is practitioner driven. In most safeguarding cases seen, there was little evidence of any oversight or input being sought by the school nurse from the trust's safeguarding team. *This has been drawn to the attention of Public Health Dorset as the commissioner of the health visitor and school nurse services.*

- 5.3.14 In CAMHS, safeguarding supervision takes place in groups on a monthly basis and is independent of clinical supervision. Safeguarding supervision is also available on an 'ad-hoc' basis according to individual practitioner need. Decisions made during safeguarding supervision are recorded in electronic client notes in line with good practice. However, there is no individual safeguarding supervision provided unless it is requested by individual practitioners (**Recommendation 1.22**).
- 5.3.15 Adult mental health practitioners receive supervision with a safeguarding element from team leaders who have not received safeguarding children supervision training. It is difficult therefore for the trust to be assured that this is sufficiently robust to support practitioners effectively (**Recommendation 1.22**).
- 5.3.16 Current safeguarding supervision arrangements for practitioners working in GUM and CASH services provided by Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust are for quarterly group sessions. These are led by the trusts' respective safeguarding named nurse and anonymised cases are discussed. Both services told us that they value the accessible safeguarding leadership and support of their Trusts' safeguarding team. While providing valuable support to staff, current arrangements do not ensure practitioners have the opportunity for regular, planned individual support and challenge to their work with high risk young people. *This issue has been drawn to the attention of Public Health Dorset as the commissioner of sexual health services.*
- 5.3.17 While group supervision sessions allow a degree of peer support and learning, particularly where staff have been involved in complex cases on a short term basis, this is not sufficient in services where practitioners carry a high level of responsibility for safeguarding within their caseloads. Findings from SCRs cite how a robust model of supervision in relation to the development of skills and judgement is strongly advocated. Good reflective supervision is the cornerstone to professional practice for those working with often challenging and complex families and child protection cases and this is best achieved in planned, regular, focused one-to-one sessions with a trained supervisor.
- 5.3.18 All newly qualified health visitors have a preceptorship programme based on the Institute of health visiting (IHV). The process has been developed over the last two years and is now considered embedded practice with dedicated training and mentorship. Embedding a strong preceptorship process in conjunction with the requirements of the IHV demonstrates that the organisation values the process and ensures that newly qualified health visitors have the appropriate skills to equip them for role.

5.3.19 There is currently no discrete preceptorship programme for newly qualified school nurses commencing employment with the healthcare trust. However there has been no recent recruitment of staff in Dorset requiring a preceptorship. Newly qualified school nurses recently appointed by the trust to Bournemouth and Poole have joined the health visitor preceptorship programme.

Recommendations

1. **Dorset CCG and Dorset Healthcare University NHS Foundation Trust should:**
 - 1.1 Ensure there is sufficient signage in minor injury units to let parents, carers and young people know that details of their attendance at the MIU will be shared with their GP and other health care professionals
 - 1.2 Ensure that the frequency of attendance of children and young people at MIUs in the previous 12 months is demonstrably considered within risk assessment/triage documentation
 - 1.3 Ensure that documentation used in the minor injury units contains prompts and trigger questions to best support effective child safeguarding practice, including consideration of the potential for hidden harm
 - 1.4 Ensure that child safeguarding practice in the minor injury units is subject to effective governance and quality assurance arrangements in order to drive continuous improvement and minimise the risk of vulnerabilities and risks to children being overlooked
 - 1.5 Put effective operational governance arrangements in place to ensure child safeguarding risk assessments in CAMHS are updated regularly
 - 1.6 Ensure that where there are children in the family or household of clients of the adult mental health service, they are clearly identified on the case recording systems, flagged appropriately if subject to CIN or child protection plans
 - 1.7 Ensure that adult mental health practitioners routinely consider the impact of parental mental health on the wellbeing of children, particularly when mental health is deteriorating and take appropriate action subject to effective governance arrangements.
 - 1.8 Ensure that adult mental health managers are aware of the cohort of children and young people within the service's caseload and that operational governance of safeguarding practice is robust
 - 1.9 Put in place operational governance and quality assurance arrangements at the frontline of services to oversee the quality of referrals to children's social care and ensure continuous improvement that facilitates effective children's social care decision-making about intervention
 - 1.10 Ensure that adult mental health practitioners discharge their responsibilities in making direct, quality assured referrals to children's social care when they identify concerns about the safety and wellbeing of a child

- 1.11 Work with Dorset County Council and Poole Hospital NHS Foundation Trust to put measures in place which ensure that looked-after children have initial and review health assessments within expected timescales, subject to effective quality assurance and within an effective joint performance management framework that drives continuous improvement across the whole system
- 1.12 Ensure that looked-after children and young people are given opportunities whenever appropriate to consent to their assessments of health and that this is evidenced in documentation
- 1.13 Ensure that robust systems are in place to minimise the numbers of young people who are looked after declining an assessment of their health needs
- 1.14 Ensure that practitioners undertaking review health assessments and formulating health plans receive appropriate training to support them well in discharging their responsibilities
- 1.15 Ensure that robust evidence-based governance arrangements are in place to monitor the delivery of the looked-after children's healthcare service
- 1.16 Review the operating model for the delivery of healthcare to looked-after children to ensure that a delivery model is in place which is sufficiently robust to meet the needs of this cohort effectively
- 1.17 Work with partners to ensure an effective pathway is in place in order that identified health needs are followed up in primary care, health visitor or school nurse services when a child or young person ceases to be in the care of Dorset County Council
- 1.18 Ensure that information from CAMHS and GPs is regularly sought and used to inform the initial and review health assessments of looked-after children and young people
- 1.19 Ensure that the safeguarding team have full access to SystemOne and other patient records systems operating across the trust in order that the involvement of safeguarding advisors in individual cases is recorded and fully supportive of their leadership and governance role
- 1.20 Ensure that adult mental health and adult substance misuse undertake level three safeguarding training in order to discharge their responsibilities effectively
- 1.21 Ensure that the trust's safeguarding training policy and delivery accurately reflects the knowledge and competency required by adult service practitioners in discharging their child safeguarding responsibilities while working with adult clients

1.22 Ensure that robust supervision arrangements are in place to ensure the specialist looked-after children's nurses, CAMHS and adult mental health practitioners are fully supported in line with *Working Together 2015* and best practice

2. Dorset CCG and Dorset County Hospital NHS Foundation Trust should:

2.1 Ensure that all eligible teenage mothers to be have access to specialist teenage pregnancy midwifery support

2.2 Ensure that ED documentation identifies who is accompanying the child or young person and what their relationship is to the child

2.3 Review waiting areas in the ED to ensure that nursing staff can monitor children effectively and respond to the deteriorating child promptly

2.4 Ensure that paediatric ED documentation contains sufficient prompts and trigger questions to support practitioners in undertaking comprehensive safeguarding risk assessments and which facilitate effective operational governance.

2.5 Ensure that documentation used in adult ED supports practitioners effectively in identifying the potential for hidden harm to a child or young person

2.6 Ensure sufficient detail about a child or young person's attendance at the ED is set out within notifications sent to GPs to facilitate effective risk assessment and follow-up in the community

2.7 Ensure that women are made aware that they will be seen alone at least once during pregnancy and incorporate this into the antenatal appointment care plan

2.8 Ensure that a formal policy is put in place to guide staff in what actions to take if a child or young person leaves the emergency department prior to treatment

2.9 Put in place operational governance and quality assurance arrangements at the frontline of services to oversee the quality of referrals to children's social care and ensure continuous improvement that facilitates effective children's social care decision-making about intervention

2.10 Ensure that child protection documentation is properly secured within the midwifery patient record in order that the record is comprehensive and all child protection information is readily available to midwives and managers

2.11 Ensure that the potential for CSE and FGM is routinely considered in midwifery practice

- 2.12 Ensure that systems, processes and paediatric liaison capacity are robust in order to provide effective governance of risk assessment and safeguarding in frontline practice in the emergency department
- 2.13 Ensure the lead safeguarding midwife role has sufficient capacity to undertake effective quality assurance and governance of safeguarding practice
- 2.14 Ensure that practitioners are well supported in their safeguarding practice through the provision of effective and robust supervision arrangements in line with *Working Together 2015* and best practice

3. Dorset CCG and NHS England should:

- 3.1 Work with GPs to strengthen participation in child protection processes through forward planning for conferences, making use of teleconferencing and other technological solutions and ensuring the outcomes of conferences are recorded in patient records
- 3.2 Work with GPs to ensure that they are fully aware of their role and responsibility to looked-after children and contribute routinely to initial and review health assessments
- 3.3 Work with GPs to ensure consistent GP practice in enabling health professionals' access to patient information stored on information systems held in common across services

4. Dorset CCG, NHS England and Dorset Healthcare University NHS Foundation Trust should:

- 4.1 Work with GPs to ensure that health visitor, school nurses, adult mental health and adult substance misuse services are routinely engaged in vulnerable families meetings in primary care
- 4.2 Work with Public Health Dorset to ensure that the school nurse and immunisation service have accurate and up-to-date information of the cohort of school age looked-after children to support high uptake of the vaccination programme in the 5-19 population

5. Dorset CCG should;

- 5.1 Work with commissioning partners to ensure that an equitable, pan-Dorset perinatal mental health pathway is established in line with NICE guidance so that women are able to benefit from a co-ordinated approach to their care

Next steps

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