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

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

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Provider services included:	University Hospital Southampton NHS Foundation Trust. Solent NHS Trust. Southern Health NHS Foundation Trust.
CCGs included:	Southampton City CCG
NHS England area:	South of England Region
CQC region:	South Region
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Contents

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Southampton. 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 Southampton, 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 71 children and young people.

Context of the review

Commissioning arrangements for looked-after children's health are the responsibility of Southampton City Clinical Commissioning Group and the looked-after children's health team. Designated roles and operational looked-after children's nurse/s are provided by Solent NHS Trust and Southampton City Clinical Commissioning Group.

Acute hospital services are provided by University Hospital Southampton NHS Foundation Trust.

Health visitor and school nurse (Public health community) services are commissioned by the Integrated Commissioning Unit on behalf of Southampton City Council Public Health and provided by Solent NHS Trust.

Child and Adolescent Mental Health Services (CAMHS) are provided by Solent NHS Trust.

Contraception and sexual health services (CASH) are commissioned by the Integrated Commissioning Unit on behalf of Southampton City Council Public Health and provided by Solent NHS Trust.

Child substance misuse services are commissioned by the Integrated Commissioning Unit on behalf of Southampton City Council Public Health and provided by No Limits.

Adult mental health services are provided by Southern Health NHS Foundation Trust.

Adult substance misuse services are commissioned by the Integrated Commissioning Unit on behalf of Southampton City Council Public Health and provided by Solent, CRI (now known as Change, Grow, Live) and No Limits.

Specialist facilities are provided by the Sexual Abuse and Referral Clinic, BRS (Behaviour Resource Service), Homeless Health Care and the Perinatal Mental Health Team.

The last inspection of health services for Southampton's children took place in April and May 2012 *as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.*

GP (Primary Care) commissioning is the responsibility of NHS England – South (Wessex)

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 women who had used midwifery services at Princess Anne Hospital. They told us:

"*My maternity care has been brilliant, including the midwives in the community. It has always been clear when my maternity appointments are and I was asked about my mental health at each appointment and about smoking too. I was also asked about alcohol and drugs at the booking appointment."*

Another new mother told us:

"My experience has been excellent. They were always honest with me about what might happen to my baby because of my mental health. I have always known what to expect and I have had a great service from the mental health midwife."

We spoke with the parents of children and young people at the University Hospital Southampton emergency department. They told us:

"I have been made to feel welcome and we have been treated really well by the staff."

"I was once here myself as a patient. I'm now here with my son and I am happy with everything."

"The staff have been excellent and the care super. The staff never stop and they look after children really well."

We heard from a young person who was a looked after child. When asked about their looked after children's nurse (LAC) they told us:

"*My LAC nurse is really lovely, she checks up on me and I contact her, it's not just once a year. She knows me. A lot has happened this month, never mind if I only saw her once a year; she listens 100%. We did the CSE risk assessment, I didn't realise I was putting myself at risk; we didn't have that at school. It now makes me think, I ended that relationship. I'm not at risk now*."

We spoke with young people at a 'young people in care council' meeting. They told us of their experiences of health services whilst being a looked after child:

"I had my health review. The nurse was nice and I got a copy of it but put it in the bin."

"It was good when the looked after doctor and nurse came to one of our meetings."

"When you have an appointment with the looked after nurse they are always late."

"I have been waiting since November 2015 for support from 'rape crisis' in Southampton. *(This review was undertaken in early February 2016)*

"I have seen CAMHS three or four times and the staff are nice. I just wish I could see just one person and not a different one every time."

"I have had to wait for a month for an appointment with my GP" and, ***"I am unable to get a same day appointment with my GP."*** The young person went on to explain how it was also difficult to see the same GP at each appointment. Other young people we spoke with told us that they could easily access same day appointments.

"I've been working with the CAMHS BRS (Behaviour Resource Service) for four years. It's good and the receptionist is nice."

"None of us knew anything about child sexual exploitation until we made the film." *(A training awareness video)*

We spoke with a foster carer who had a wide experience of using health services in Southampton in relation to looked after children. When asked about what worked well with services provided to looked after children and carers they told us:

"*The way that they deal with children; they are very sympathetic and very professional and this is really good for me as a foster carer and for the children. This way of working puts the children at ease and by having regular medicals and building the relationship with the same specific Dr who completes the LAC medical the children are happy and seem quite upbeat about it*."

When asked about the availability to request an alternate date, time venue for looked after children health reviews they told us:

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"*I can rearrange the time and date if needed, but I have never asked to change the location of where the assessments have taken place, they are completed at the Community Clinic.*"

When asked if they received copies of the health information following the LAC health assessments of the children in their care they told us:

"***Yes, I get copies of the initial and review health assessments and they provide a true account of how the medical went***."

When asked if they were aware of who to contact for advice and support the foster carer told us:

"***Yes I am able to contact the LAC nurse, but BRS contact is through the child's social worker. I do feel listened to and when I take children for health appointments they always ask who I am, so I make sure I take my medical cards. They respect that I have good information about the child as they are in my care. An example of this was in relation to a baby in my care who was born four weeks early and had on-going problems with their chest which really concerned me. I contacted the LAC team and they were really supportive of me and supported me taking the baby back to clinic. The outcome was that the baby ended up on medication and this working closely together ensured this babies health needs were fully explored and met.***"

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 Expectant women living in Southampton currently access maternity services through their GP. GP referrals seen were variable, with not all referrals containing full details of any social vulnerability that might present. We were advised during our review that risk assessment of women who access maternity services directly from the early pregnancy unit (EPU) thereby bypassing their GP, is not routinely informed by information held on their primary care record. We have since been advised that this is not the case. Referrals to the EPU are made by the woman's GP and direct referrals are not accepted. If a referral for antenatal care has not yet been received and the pregnancy is sufficiently advanced, i.e. greater than 12 weeks, the EPU will contact community midwifery service to expedite booking and will also write to the GP and inform them. The booking midwife should then contact the relevant GP to collate information. If woman is less than 12 weeks they are referred back to the GP and not to midwifery service. EPU will also liaise with the GP if there are concerns about emotional or mental health of a patient referred to them.

It is important that GP initial assessment provided to maternity services is as comprehensive as possible so that decisions around support can be made at the earliest possible opportunity. ***(Recommendation 2.1)***

1.2 Questions in relation to the risk of domestic violence are not being asked routinely during pregnancy and women are not being routinely seen alone to better assess risk. We are aware that an audit of maternity notes to evidence direct questioning of domestic violence is currently underway. ***(Recommendation 2.2)***

1.3 First time mothers-to-be and those with identified vulnerability are offered enhanced midwifery support. Specially designed, enhanced hand-held maternity notes are used to guide the women through the scheduled routine antenatal appointments. However, we were advised that there are currently no 'easy read' versions of antenatal records for those parents with learning disability.

1.4 Mothers to be who are identified as needing enhanced support are cared for by case-holding teams. These midwives have lower case numbers to allow for more intensive support work. One new mother who had recently had their baby and had been supported by the team described their care as, 'brilliant.'

1.5 Records examined during our review demonstrated that the recording of father and/or partner details in the antenatal records appears ad-hoc. Within the antenatal documentation there is a formal section where five key areas of risk relating to partners are required to be answered. The Midwife is reliant on the women knowing and disclosing this information and then recording whether those answers have been given or not. In one case, although the father's name had been recorded, details of his known risk taking behaviour and substance misuse had not. Multi-agency safeguarding hub (MASH) health navigators told us that referrals to MASH from midwifery routinely do not include the name of the baby's father. The navigator frequently makes calls back to the service to ascertain information which should be set out in referrals of an acceptable standard but midwives are often unable to supply this information because, even if they have asked the right question, they are not always recording the answers. This is a serious deficit and is a common feature of serious case reviews. ***(Recommendation 2.3)***

1.6 The named safeguarding midwife and the specialist substance misuse midwife attend a multi-agency forum set up to consider the risks presented by mothers-to-be who misuse substances. The meetings include representation from paediatrics, adult substance misuse and children's social care, who had begun attending the meetings only very recently. However, the health visitor service is not represented even though they would have a key role in providing support to families and children, and this is a gap. ***(Recommendation 3.1)***

1.7 We reviewed the notes made of discussions undertaken for one of the cases in midwifery we were tracking across services and found them to be superficial and without any clear recorded outcomes. For example, whilst it was clear that one woman had continued to use controlled drugs during the early part of her pregnancy, there was no plan documented about how she might be supported to change her behaviour and better protect the unborn child. We saw a section of the form entitled 'management plan'. This section was made up of three parts; antenatal, intrapartum and postnatal. Only the postnatal section contained a direction which was to 'monitor baby and manage withdrawal as necessary'. The other two sections had been left blank. This multi-agency forum has the potential to be highly effective in identifying vulnerabilities and risks to unborn children at an early stage, engaging parents with early help support and putting into place multi-agency support plans to minimise risk of harm to the unborn. This is particularly the case since children's social care joined the forum, but the potential impact of this forum is not being realised

The absence of any objective driven antenatal plan means that opportunities to support the mother-to-be to minimise the risks to her unborn child through pregnancy were missed. ***(Recommendation 2.4)***

1.8 Southampton University Hospital emergency department (ED) staff are vigilant to women attending the unit with self-harm or mental health concerns who are pregnant, and appropriate safeguarding information is shared with midwives. This facilitates a prompt response by the midwives to offer support as soon as practicable.

1.9 Children and young people who attend the ED are safeguarded well. There is clear guidance available to staff on how to respond to any safeguarding or child protection concerns and there is a safeguarding flow chart that guides staff through the pathway which helpfully, includes the thresholds for referral to MASH. Children and young people who leave the ED without first being seen or assessed are followed up appropriately by practitioners to ensure their safety.

1.10 ED paperwork in respect of paediatric attendance is good. It includes details of parents, persons with parental responsibility, and name and relationship details in respect of who is accompanying the child to the department. There are sections to prompt the practitioners to ask about health visitor, GP and social worker involvement, as well as any other agencies involved. Mandatory questions relate to child protection and safeguarding concerns. If any concerns are identified then an information sharing form must also be completed. A specific toolkit for use when child sexual exploitation (CSE) is not currently in use, but there is a task and finish working group in place to address this. There is a warning 'flag' which can be activated on the Symphony IT system where CSE may be indicated.

1.11 All information sharing forms are reviewed by the paediatric liaison specialist nurse, as are the discharge notification letters. This means that on some occasions the paediatric specialist nurse may duplicate the information contained on the discharge letter, but we were told that the information sharing forms are usually produced more quickly than the discharge letters which means that professionals will be in receipt of important information at the earliest opportunity.

1.12 In children's ED, records examined demonstrated that although there is a visible prompt to take into account the 'voice of the child', it is not always used and therefore it is not always clear that the child or young person has been included in any assessment or planning process. Accounts recorded were not always of sufficient detail to demonstrate healthy professional curiosity. This was contradictory to the records examined in adult ED (in respect of hidden harm) which demonstrated detailed accounts of discussions undertaken with adults regarding access to children and associated caring responsibilities. ***(Recommendation 2.13)***

1.13 Public health nurses work closely with 'No Limits', a charity which offers free and confidential information, advice, counselling, support and advocacy for children and young people under 26 who live in Southampton and Hampshire. Mandatory health requirements are delivered by public health nurses and, although staffing levels are relatively low in comparison the population of children in the city, the use of dedicated practitioners provides a time limited targeting of early help services for children. This means that if identified and referred children are provided with service in a timely way that may prevent the need for more intrusive statutory intervention at a later date.

1.14 Public health nurses undertake regular meetings with GPs in their areas where vulnerable children, young people and families are discussed. This is in response to an identified area for development in public nurse and GP liaison. Every GP surgery has a liaison health visitor and this means that there are good opportunities to exchange and update information with the GP as the primary record holder for health. This system ensures a good flow of information across the teams and enables health visitors to be informed of any new issues or developments that may affect their practice.

1.15 There is one public health nurse who maintains contact with home educated children and their families via a parent led support group. However, they are not routinely made aware of all home educated children due to current information sharing arrangements with the local authority. The nurse estimates that at present she has identified and is working with 50% of home educated children within her catchment area. There is a similar arrangement for children of traveller families whereby the nurse facilitates a child led drop session with agreement from within the traveller community. Both of these arrangements ensure that many children who may be hard to reach have access to the health child programmes and health education as well as providing access to a health professional. There is more to be done however, to accurately identify home educated children and ensure their health and wellbeing needs are appropriately met. **A letter will be sent to Public Health advising them of this matter.**

1.16 Although we were advised that staffing levels are relatively low in school nursing in comparison to the population of children in the area, dedicated practitioners are providing a good, time limited targeting of early help services for children to ensure their needs are met.

1.17 We found access to Child and Adolescent Mental Health Services (CAMHS) support for young people with mental health needs in Southampton is good with all referrals being triaged within 24 hours and prioritised for appointments according to need. Cases deemed urgent are seen within 72 hours or sooner and routine cases are seen within two weeks. No concerns relating to access to tier three CAMHS were raised through our discussions with commissioners, the CAMHS provider and partner agencies, visits to services (including two GP practices) and conversations with young people. As this is a commonly an area of real concern for all stakeholders, this is a very positive finding. We were advised that there are currently a high number of vacant posts in CAMHS following service transformation which could potentially impact on access to CAMHS. However, we are aware that vacancies are not significantly high in comparison to our findings in other areas of the country and managers are taking action to fill vacant posts. Intervention plans have recently been introduced which have been developed to be child friendly putting the young person at the centre of that intervention plan.

Although we understood that outcomes from the therapeutic needs assessments are usually also produced in a child friendly version so that the young person has a full understanding of their assessed needs and how these will be addressed through therapeutic intervention, this was not evidenced on all case records examined.

1.18 We did see CAMHS letters written to young people in an accessible and personalised style, setting out useful summaries of the therapeutic session and what the outcomes from the session had been. We also saw evidence of positive outcomes from young people's engagement with services, with improved relationships and greater stability within families as a result.

***Case example**: Teenage male who had been engaged with CAMHS since 2013. He has history of substance misuse and we were advised was originally referred to CAMHS by the 'drug and alcohol service'. He has been admitted for in-patient mental health care on several occasions.*

He is currently receiving multi-agency support through a universal help assessment (UHA) which has replaced common assessment framework (CAF) locally, co-ordinated by children's social care. His social worker attends his CAMHs reviews on a regular basis and the CAMHS clinician reported good interagency relationships and co-operative working. The UHA was not contained on the case record however, and CAMHS practitioners had not been proactive in ensuring that they had this plan and that it formed part of the young person's case record as well as informing the work with the young person.

As the parents of the young person did not have English as a first language, the psychiatrist ensured that the letter which was routinely sent to the young person, GP and social worker was also produced in a version for the parents in their first language. This is sensitive to the needs of the young person and his parents and helpful in ensuring that they are kept fully apprised of progress in an accessible and meaningful way.

1.19 Although CAMHS practitioners report good access to tier four, in-patient mental health provision which is usually sourced close to the young person's home community, we have since been advised that the service has significant difficulty accessing tier four beds which results in some young people being admitted to paediatric wards until a suitable bed becomes available. Where young people are placed at distance for in-patient treatment, CAMHS practitioners make effort to remain engaged through a range of means; such as conference call participation in case reviews and attendance at discharge planning meetings, and this is good practice. The service demonstrates success in supporting young people with sometimes severe eating disorders and low BMIs at home very effectively, through daily visits and intense support, rather than the young person having to be admitted for in-patient treatment.

1.20 Adults with mental illness are referred to their local geographical community health team where all referrals are screened on a daily basis by a senior nurse and a medical practitioner. Assessments should include any risk to others, including any children in the family or who the service user may have access to. However, we saw variable practice by adult mental health practitioners in recording the details of any children in households and, where recordings were made, they would often be limited to first names and ages. This information is often insufficient to identify the children who may have different surnames and/or addresses which may have to be accessed quickly. **(*Recommendation 6.4)***

1.21 There is a broad base of early help support for young people and adults with substance misuse issues giving good, flexible access to support services. No Limits, a third sector organisation, offers support from age 10 up to the age of 24 years. CRI (Southampton drug and alcohol recovery services) offer brief interventions and care co-ordination service to adults with substance misuse issues and will work co-operatively and jointly on cases which are engaged with Solent's structured intervention and treatment service (SIS) for ages 10 and upwards, including adults. We visited SIS during this review and looked at a number of cases, some of which were being co-worked with CRI which would be the service most likely to attend child in need and child protection forums, although SIS practitioners also attend as appropriate for the individual case. Practitioners reported variable liaison with individual midwives. Although they were positive about the substance misuse maternity liaison forum being a good opportunity to discuss cases, it was difficult for practitioners to identify specific outcomes from these.

***Case Example**: An adult mother with a previous child in the care of the local authority as a result of her substance abuse, was pregnant with her second child.*

With a change in contract arrangements for adult substance misuse, she was transferred to the voluntary sector provider but found it hard to settle with the new service. The case was then co-worked by No Limits and Solent NHS Trust's structured intervention service (SIS) to provide her with tailored support as she made the transition into long-term support from the new service.

The baby was born early 2015 with significant withdrawal symptoms and was subsequently in hospital for several months. There was close liaison in this case between midwifery and the substance misuse services with the SIS practitioner fully engaged with discharge planning meetings.

The baby is now a looked-after child in a specialist foster placement. The mother is currently clean of substance misuse and continues to engage well with the No Limits and SIS practitioners.

1.22 Basing 'early help' within the MASH facilitates the prompt engagement of children and families with early help support needs. The Common Assessment Framework (CAF) has been replaced in Southampton by the Universal Help Assessment (UHA). In reviewing cases subject to UHA, we did not see separate UHA plans actively and routinely obtained by health practitioners being used to ensure these are informing the practitioner in their day to day work with children. While social workers should be sending these out, health practitioners have an equal responsibility in ensuring they have them and us then. We saw some passivity during our review in relation to this in several services including CAMHS and Solent's adult substance misuse ***(Recommendation 1.1)***

2. Children in need

2.1 Women who are already known to adult mental health who have a significant or severe mental health diagnosis such as bi-polar or schizophrenia, are accepted by the perinatal mental health service. Mothers who do not meet service threshold are usually cared for by their GP. Criteria for the service is quite limited and women who are already known to adult mental health and/or have pre-existing mental health issues or who are unlikely to keep their baby are not eligible for the specialist service. Not all women referred to the perinatal mental health service are accepted for support and one new mother told us that she was disappointed that she had only had an assessment from the service and that she felt she needed some further ongoing support but did not know how or if she could access it. ***(Recommendation 2.5)***

2.2 The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young families, aged 19 years or under. A specially trained family nurse visits the young family regularly, from the early stages of pregnancy until their child is two years of age. Practitioners work with the young family to understand aspects of their lives such as the risk of domestic abuse, exploitation, smoking, alcohol and drug use and healthy eating. This enables the mothers-to-be to increase their opportunities of ensuring a safe pregnancy, safe delivery and infancy of their new-born.

2.3 The provision of an FNP within an area is a strength as this provides good outcomes for vulnerable young mothers and children. Inspectors were impressed that the Southampton FNP has initiated two innovative services; 'Bright Beginnings', in partnership with 'No Limit's' for vulnerable parents who don't meet FNP criteria, and, in partnership with a local domestic abuse charity and local premier league football team, a focus group is planned to be held at the football stadium aimed at young fathers and a discussion about the power balance in relationships. This is an innovative and proactive way to mitigate the risks of domestic abuse within this cohort of young people.

2.4 CAMHS support for children and young people who attend the UHS ED following an incident of self-harm or other mental health problem is good. There are two CAHMS liaison nurse specialists working across the ED and the paediatric assessment unit who can be accessed to provide advice to staff and also provide assessment of children and young people. This is good and innovative practice. Systems and processes are well established to ensure that this highly effective level of support is sustainable and not reliant on the good interpersonal relationships that exist between current practitioners who have recently transferred into these roles following service reorganisation.

2.5 Children who attend the ED following overdose are all admitted overnight in order for a CAMHS assessment to take place. In some instances, children will be reassessed before safe discharge is arranged. Children are generally not kept as inpatients beyond 48 hours and are usually discharged within 24 hours. There are some occasional exceptions to this for a small number of young people who are frequent attenders and not regularly admitted as part of a bespoke multi-agency plan.

2.6 In the adult ED, the vulnerable adult support team (VAST) has been established in order to focus on the psychosocial needs of adults and young people aged 16-18 years who attend the department. The team are vigilant in identifying the children of those adult patients who attend the department following risk taking behaviours or who have acute mental health concerns. The adult pathway identifies potential hidden harm which includes mental health, self-harm, domestic abuse, substance use, homelessness and honour based violence and ensures a dedicated and detailed discussion takes place with patients prompting the practitioner to explore parental and child care responsibilities with them and address any associated risks. On occasion, young people up to the age of 18 years come under the child protection team and are covered by child protection legislation and safeguarding guidance, including issues of domestic violence, substance misuse, homeless etc. The VAST team triangulate information in relation to adult parent/carers who may post a risk to children and share that with the child protection team

2.7 We saw that the contraception and sexual health services in Southampton has made arrangements to ensure young people with a variety of different needs could access the service as flexibly as possible. For example, specialist sexual health outreach nurses run weekly clinics at six of the city's secondary schools and at three of the city's colleges. In addition, the service operates a weekly drop-in service at the substance misuse centre. This ensures that young people can obtain access to the service at a time and place that best suits their individual needs without having to travel to one of the service's locality centres. Further, a dedicated safeguarding doctor-led clinic held at the Royal South Hants Hospital (RSH) held every Wednesday afternoon enables the service to offer extended appointments for identified young people who are considered more vulnerable so that identified risks can be explored in depth.

2.8 We did not see copies of child in need plans routinely being part of case records for children subject to child in need measures in the adult substance misuse service. Practitioners acknowledged that they are not proactive in ensuring that they have received these from children's social care. It is essential that the case record is complete and that key multi-agency plans are actively informing practitioners' care planning and day-to-day work with a family. **A letter will be sent to Public Health advising them of this matter.**

3. Child protection

3.1 Expectant women are not being routinely seen alone or asked questions in relation to risk of domestic abuse at least once during their pregnancy. We saw evidence in only one case examined where the relevant section on the antenatal record had been completed. Women we spoke with who had recently had their babies told us that either the question around domestic abuse had not been asked or that they had been told 'they didn't need to answer.' Research shows that domestic abuse can often escalate or present for the first time during pregnancy and should be explored with women once as a minimum expectation to safeguard her and the unborn child. Where expectant women present with female genital mutilation (FGM), cases are routinely referred to the MASH in line with good practice. ***(Recommendation 2.2 as at 1.2 above)***

During our review we spoke with new mothers about their experiences of midwifery services. One new mother we spoke with told us that she had not been asked about the risks of domestic abuse in any form during her pregnancy and further that she had not been offered a meeting with a midwife without her partner being present to better assess risk to both her and the unborn child. This demonstrates that the midwifery team were not properly assessing the risk of domestic abuse and so opportunities to bring these risks to the attention of the local authority were missed.

3.2 Birth plans to safeguard the unborn are detailed and in all cases seen, followed diligently by labour, post-natal and neonatal staff once the infant was born. The named midwife is proactive in liaising with children's social care to create temporary plans where formal processes have not yet completed and the formal plan issued.

3.3 We saw that evolving concerns about vulnerable mothers-to-be were recorded on the electronic patient system used by the maternity service and then printed off on yellow coloured pages for the hard copy files to ensure midwives were properly alerted to such risks at each meeting with the woman. The 'yellow pages' is the principal mechanism for recording all concerns and for documenting action taken in chronological order throughout the pregnancy. It is also used as supporting information for any safeguarding referrals made to the MASH. However, we found that the records on these pages does not fully analyse risks to the unborn baby. This was borne out by the MASH referral forms for three of the cases examined. In each of these cases, the MASH referral form simply logged the identities of the mother and father and referred the reader to an 'attached' copy of the yellow pages concerns form. This means that risks to an unborn child are not being properly expressed when making a referral which might adversely affect the decision making process. ***(Recommendation 2.6)***

3.4 Nurses from the FNP try to attend every child protection conference they are invited to, including core groups and looked after children reviews, with a deputy attending if the allocated nurse is on leave or not available. We saw that preparation for the child protection conferences results in a written report which sets out and clearly articulates the current level of risk. This means the conferences are better informed in their decisions about children who are subject of the conference.

3.5 At the UHS ED, children and young people are referred appropriately to children's social care where practitioners identify any safeguarding or child protection concerns. Referrals examined during our review contained a proportionate amount of information that supported the decision making process. However, health practitioners told us that feedback on the quality of referrals or outcomes are often not provided to them. The named paediatric consultant has escalated the issue via the safeguarding team.

3.6 There are a number of systems in the ED that have to be checked in order to verify information about children and whether or not they are subject to a child protection plan. This can be time consuming to an already busy workforce but nonetheless essential as part of the process of ensuring the welfare of children.

3.7 The local area has been in discussion regarding the required implementation of the national child protection information system (CPIS). This is a national alert system that identifies any child who has a child protection plan in place and when implemented should address the difficulties of multiple checking a number of different systems.

3.8 In public health, a mapping exercise has been undertaken in conjunction with the local authority in respect of attendance at child protection conferences. The expectation now is that a member of the public health nursing service will attend all initial conferences and that a decision will then be made about which health professional is most appropriate to attend subsequent review meetings if at all. This ensures best use of resource time and appropriate attendance at meetings.

The expectation is that all public health nurses will provide a report for initial conferences and only those review child protection conferences where they have had contact with the child or young person and have any information to report. However in one case seen a report had not been provided and there was no explanation as to why this had not happened. **A letter will be sent to Public Health advising them of this matter.**

3.9 Practitioners from the Contraception And Sexual Health (CASH) service do not routinely attend child protection conferences unless they are involved in a young person's on an ongoing basis through outreach work. However, in all cases, whether staff attend or not, reports are prepared and submitted for the conference. In one case we sampled where the practitioner had attended the conference, we saw that the advance report analysed and articulated risk in sufficient detail to support effective decision making.

3.10 In CAMHS, psychiatrist led cases had care plans in letter form rather than plan form as is routine practice in the service for cases which are led by a nurse or other practitioner. This can bring an additional challenge in ensuring that child protection plans are fully informing the development of care plans when letter formats are in use. Managers in the service acknowledged that a consistent approach may be beneficial in helping to embed best safeguarding practice.

3.11 There is evidence of good attendance at child protection case conferences in the majority of child protection cases we have sampled across services, although in some monitoring of practitioner attendance by operational managers is unclear or underdeveloped. In some services, such as adult substance misuse, managers told us work is in hand to strengthen this with children's social care as practitioners were not always invited. ***(Recommendation 4.1) A letter will also be sent to Public Health advising them of this matter.***

3.12 Both of the GP practices we visited had clear procedures in place for responding to invitations to child protection conferences. Both GPs were able, from time to time according to circumstances which includes workload, to attend conferences in person. In every instance we saw that reports were provided for the conference in good time and to a good level of detail to help inform the decision making process.

3.13 We did see some elements of positive 'Think Family' practice within adult substance misuse services, including practitioners routinely undertaking home visits to ensure safe storage of medication when they are aware of there being children in the household. In one case we reviewed, the substance misuse practitioner had identified risks to a child and had made an appropriate referral to the MASH. The service is not actively working to establish a 'Think Family' model and overall we identified a number of areas for development. The current IT system in use is inhibiting rather than facilitating the service's ability to demonstrate that they prioritise the safety of children while working predominately with adults. The system does not reflect key learning from national serious case reviews, such as the need to identify children in the household of clients of adult service users rather than only recording known children of the client.

Even where it was known that there were children within a case, we found details and information about children hard to find. Alerts are not put onto the system routinely to immediately advise practitioners and managers to the presence of children in a case and this clearly elevates risk that child welfare may not be prioritised. ***(Recommendation 4.2)*** **A letter will also be sent to Public Health advising them of this matter.**

3.14 In adult substance misuse, it is a clear management expectation that practitioners attend child protection conferences and submit written reports in advance. We examined evidence that this does take place but there is no monitoring or quality assurance process in place to ensure compliance. We also saw that child in need and child protection plans and minutes from conferences are not consistently present on individual case records. While it is the responsibility of children's social care to send these to all key professionals involved, it is beholden on health services to ensure they have these and that they are part of the case record, guiding the work of practitioners. Operational governance of safeguarding practice within the service is weak and the safeguarding lead acknowledged that best practice is currently not being modelled. Positively, managers told us that they were aware of the cohort of young people including those on child protection and child in need plans, although it was difficult to see how they achieve this given the challenge of the IT system and sometimes poor case recording. ***(Recommendation 4.1 as at 3.11 above)***

Case Example: *a woman aged 36 with young children. She is supported by CRI in relation to her substance misuse.*

On accessing the case record, an alert immediately opens to inform the practitioner that there are children in this case.

The practitioner identified risk to the children and made a referral to the MASH. However, there was no evidence in the case record to indicate exactly what the risks were or how the practitioner evaluated these. No copy of the referral was retained on the case record to ensure an audit trail. There was no evidence of managerial oversight of case recording and records management to ensure records were comprehensive and complete.

3.15 The presence of a CRI substance misuse navigator in the MASH is positive, ensuring prompt access to specialist information and expertise to support effective MASH decision making.

3.16 Southern Health Trust recognise the limitations of the IT system used in adult mental health services and have introduced a way to electronically capture referrals to children's social care where there are concerns about the safety of a child. However, it became evident during our review that either adult mental health practitioners were not using the system or there was a problem with data integrity. We were told that referrals to children's social care via the MASH were usually made initially by phone and then followed up with a letter or email. However, we were only able to find physical evidence of one completed referral covering a six month period. Inspectors expressed concern at the potential under identification and referral of children who may be vulnerable and living with adults with mental health problems.

3.17 There is inconsistency in the involvement of adult mental health services in child protection conferences and core group meetings. In some cases examined we were unable to establish why adult mental health services had not been formally asked to contribute to conference and in one case had only attended to provide emotional support to the service user. The trust's current policy on not uploading child protection conference minutes and plans onto the service user IT record makes it difficult to obtain a comprehensive overview of events within the family.

Inspectors also found poor communication between adult mental health practitioners and other health professionals working with client family members, such as adult substance misuse practitioners and health visitors. We could find no evidence of any liaison outside of formal child protection conferences, and discussion around potential risk and planning was sometimes limited to conversations with their client and family. This is an area for development for both adult services and health visitors ***(Recommendation 5.1) A letter will also be sent to Public Health informing them of this matter.***

A mother was referred to adult mental health services by the family GP who was concerned that her mental health had significantly deteriorated, she was showing psychoses and it was believed that 'voices' were telling her to harm her youngest child. There had been a historic incident where she had previously tried to poison herself and one of her other children when they were young.

A referral was made to MASH and a referral form completed. The practitioner completed the trust's incident reporting system and escalated to their team manager in line with local policy.

However, the mother's mental health fluctuated and she was assessed as part of an application for section under the Mental Health Act 2007 and discussions as to her suitability for accessing care and treatment by the hospital at home adult mental health service.

The family were allocated a social worker and during the ongoing assessment the father told professionals that he was taking his wife and child to stay with his eldest daughter in another county for a rest. Southampton adult mental health services liaised with the eldest daughter's home town mental health service who said that they did not think she was appropriate for their service and declined any support.

The Southampton adult mental health worker closed the case. There was no liaison with school nursing to establish any risk to the child or to alert the school nurse to the potential of any impact on the child due to their mother's mental health.

The case was referred back to the CCG by CQC inspectors and has since been reviewed by all providers involved. Learning is being taken forward and shared amongst those multi-agencies and health professionals. The safety of the child has also been confirmed

3.18 In midwifery and the FNP, we did not see the use of a CSE risk assessment tool. We would have expected to see this as routine practice. Although we understand that a CSE tool is in development for use in midwifery and across UHS, the fact that there the fact that there is no other method to prompt practitioners to assess CSE risk is considered a gap. ***(Recommendation 2.7)***

3.19 A specific toolkit for use when CSE is suspected is not currently in use in UHS ED or maternity services, but there is a task & finish working group currently operational to address this issue. If a CSE alert is received, a flag can be placed on the 'symphony' patient record. This flag will prompt a confidential email or letter. The safeguarding lead reviews the alerts every six months and discusses them with the child protection team.

3.20 The CASH service receives referrals about young people at risk of CSE from the operational multi-agency exploitation panel. In addition, staff at the service told us they use the multi-agency risk assessment tool (SERAF) to consider risks once the potential for exploitation has been identified when the young person enters the service. However, we did not see completed examples of this form and learned that there that there have been no referrals out of the service for CSE. Given that Southampton is a port of entry to the UK and has a large population, many of whom are transient, so we found the absence of such referrals to be unusual, warranting further exploration by the trust. ***A letter will be sent to Public Health advising them of this matter***

4. Looked after children

4.1 Most children and young people who are taken into care by Southampton City Council can expect to have their health needs assessed in a timely way. Current service information shows that 82% of young people coming into care are having their health needs assessed within target timescales, 80% are receiving dental checks and 87% have up to date immunisations, demonstrating significant improvement.

4.2 All initial health assessments (IHAs) are undertaken by the designated doctor and team of paediatricians unless the child is immediately placed out of the Southampton area. The overall quality of the IHAs and review health assessments (RHAs) undertaken by the team were of exceptional and consistent quality.

***Case Example**: One of the tracked cases we looked at in a number of services was for a baby who had been taken straight into care at birth. There was a complex history of service engagement with the family including both parents having engagement with learning disability and adult mental health services. Previous children had also been taken into care.*

The baby's IHA had been undertaken by the designated doctor for looked-after children. In common with all the IHAs undertaken by the designated doctor's team of paediatricians, this IHA set out a fully comprehensive health history of the family.

This is likely to be of great value to this looked-after child in the future as they begin to enter adulthood and have the innate and natural desire to know where they have come from and who they are.

4.3 In all cases examined we saw that the IHAs undertaken by the designated doctor and Southampton paediatricians set out comprehensive parental health histories to inform the young person. As young people frequently tell us that a lack of parental health history can have long term detrimental effects on them as they enter adulthood, this is an important issue and something that Southampton looked after children health practitioners achieve well.

***Case example**: female aged 15 became looked after as at risk of CSE and was placed out of area in neighbouring authority. She was refusing to have an initial health assessment by the paediatrician. The looked-after child designated doctor sets a clear and explicit standard that all IHAs will be undertaken by paediatricians under her supervision and a robust risk assessment approach is taken to any exceptions.*

Following discussion in the looked-after child health team it was agreed that one of the specialist looked-after child nurses would meet the young person with her social worker and undertake at least a partial health assessment under the oversight, guidance and supervision of the designated doctor.

This took place and the young person was comfortable with having a partial health assessment which was reviewed by the designated doctor. Although this stepped outside of full compliance with guidance, this pragmatic approach was transparent and well managed, enabling the young person to engage with their health assessment to the extent that they wanted.

4.4 The looked after children's team, including the designated doctor, specialist paediatricians, the named nurse and two specialist nurses, undertake all RHAs in what is an unusual, although not unique, service delivery model whereby children and young people have their health reviewed throughout their care journey by a very small specialist team. This facilitates connectivity between reviews and when working well, is likely to deliver a high quality service as we found in Southampton. There are risks with this service model however, which are discussed under the leadership and management section of this report below.

4.5 It was evident in all case records examined, that paediatricians and the specialist looked-after child nurses spend significant time with young people, giving diligent attention to eliciting their likes and dislikes, aspirations and concerns etc. and recording this in great detail in IHAs and RHAs. Surprisingly however, in no case record did we see the child actually quoted, even where the child was described as 'highly articulate'. All this detail is being recorded on the assessment documentation in the third person and therefore, the actual voice of the child is not strong in records seen. ***(Recommendation 4.3)***

4.6 Health plans, while demonstrating the same attention to detail shown in other documents, were not always fully SMART with some loose timescales seen in relation to planning care and support.

4.7 With the current high numbers of out of area placements for looked after children there is a recognised challenge to ensure this cohort receive a similar quality service. Out of area foster carers are encouraged to bring young people into clinics where possible and the looked after children nurses will travel to young people where appropriate. The designated doctor and named nurse quality assure the majority of the out or area initial health assessments, review health assessments and health plans supported by the wider clinical team. This process is not effective and there is an area for development in relation to quality assurance for both in area and out of area assessments. There is no formalised and criteria based quality assurance framework in place and we examined an out of area case example which clearly demonstrated the impact of this gap. Senior practitioners in the service acknowledged this area for development. ***(Recommendation 4.4)***

Case Example: *male unaccompanied asylum seeking child (UASC) aged 16 years. This young person was immediately on becoming looked after by Southampton, placed out of area in a northern local authority.*

His initial health assessment was therefore undertaken by a paediatrician in the other authority area. The IHA was undertaken within timescales and the paediatrician, sensitive to the wishes of the young person, did not carry out a full examination of his lower body. She was able to ascertain that the young person had a significant issue with his legs and the assessment documentation identified the need for him to have a full lower limb examination.

However, the health plan formulated by the clinician as a result of the assessment was poor. Timescales were identified as 'soon' rather than a specific time limit put on actions to be taken. Responsibility for referring for an examination of the young person's lower limbs was delegated to the looked-after child nurse in the local area, rather than the paediatrician actioning a referral at the time of the IHA and recording that this had been done. There was no indication that the referral had been made and the necessary specialist examination carried out.

The IHA and health plan had been sent back to the Southampton looked-after child paediatric team and had been signed off and sent for filing by the paediatrician. Insufficient rigor had been brought to bear in this quality assurance activity and there had been no follow-up by the Southampton looked-after child team with the clinical team in the other authority area to ensure this young person's identified health needs had been addressed.

This case was referred back to the designated doctor for looked-after child to ensure issues were followed up with the young person's clinical team.

4.8 The designated doctor and health team for looked-after children has developed a number of excellent bespoke templates for looked-after child health assessments. These are largely based on the old British Association for Adoption and Fostering (BAAF) documentation but with additions which strengthen the assessment and increase the likelihood of the young person engaging with their own health planning, an example being the bespoke health plan which includes the date of the next due health assessment and sets out to whom copies will be sent. This includes the GP, foster carers, birth parents if applicable, the health visitor, social worker, and the independent reviewing officer (IRO) who chairs the young person's statutory looked-after child review. This is facilitating good join up between the health and social care components of the child's journey as a looked-after child and promotes a whole team around the child approach.

There is scope to develop this join-up further, tied in with identifying tighter timescales in the child's health plan linked to the child's statutory looked-after child review. This would enable the IRO to more easily monitor delivery of the child's health plan at the review. The service has not developed a child friendly or age appropriate version which could usefully be given to the child or young person.

4.9 A template has been developed by the designated doctor for the initial health assessment which facilitates a comprehensive assessment of the young people needs and reflects the particular physical and emotional health issues and likely needs of this highly vulnerable cohort of young people. It has not been based on the latest guidance on assessing the health of UASC issued by the Department for Health however, so there is scope to strengthen this very good template further.

***Case Example**: male aged 14 years from Afghanistan.*

The paediatrician undertook the young man's health assessment using the bespoke template developed by the Southampton designated doctor for looked-after children. It was clear that the clinician had taken time with the young person and had forged a trusting relationship quickly.

The IHA included some details of the young person's family and parental health history. His father and brother had been killed and his mother, still in Afghanistan, suffered from jaundice.

Key issues, including the potential for post-traumatic stress disorder were included in the resultant health plan although some timescales were loosely defined, stating ongoing or asap, rather than specific and monitored.

4.10 Looked-after children with emotional and mental health needs receive very robust, child centred support promptly from BRS when emotional and mental health needs are identified in what is virtually a dedicated service for looked after children. One of the specialist nurses sits on the BRS therapeutic panel. The looked after children health team meet bi-monthly with BRS enabling joint exploration and discussion of cases, and provides an element of supervision to the looked after children practitioners.

4.11 Young people looked after are not benefiting from the use and evaluation of strength and difficulties questionnaires (SDQs) as there is no provision of SDQs in Southampton and there has not been for several years. This is not compliant with Department for Education requirements and is not acceptable. We understand that there has been dialogue between health and children's social care about the provision of SDQs for some time but progress has been slow. SDQs, when utilised effectively, can be very helpful in identifying and tracking a child's emotional health and wellbeing whilst in care. This is also a missed opportunity to help older looked after children engage with their own emotional and personal growth from year to year. ***(Recommendation 4.5)***

4.12 There is a strong offer of health support to care leavers even though the service is commissioned to age 18 only. The specialist health team continue to actively support many young people beyond this. The practitioners within the looked after children nurse team are diligent and determined in their efforts to ensure actions are followed up by children's social care and other professionals, and we saw this evidenced strongly in case records examined.

***Case Example**: male care leaver aged 18 years. His last review health assessment was undertaken as per routine practice by the specialist looked-after children's nurse who knew him well. As a care leaver he received a comprehensive health history on the Southampton bespoke template. Although he had his last RHA in August 2015, his records identified that he requested to see the looked-after child specialist nurse in a year's time and this was included in his health plan.*

There was clear connectivity with his previous health assessments and his last health review was demonstrably sensitive in nature and very young person focused.

In the course of the assessment, the looked-after child nurse identified a safeguarding risk to a small child whose family the young person had been holidaying with. He had rescued the child from drowning but she identified concerns about the supervision and care of the child by the parents. She made a prompt and appropriate contact with children's social care and referral was made to the MASH.

The health review identified concerns about the young person's anger management and mental health and the specialist nurse was dogged in her ensuring that these concerns were followed up by his GP and social worker, making repeated contact to ensure he received appropriate support.

The specialist looked-after child nurse wrote a personalised and accessible letter to the young person following his assessment as per routine practice for care leavers.

4.13 In one case we sampled in the CASH service, we saw that practitioners had been successful in engaging a very vulnerable young person who was looked after and that they had referred them to local community services for support. However, there was no evidence of sharing information from their interventions with the looked after children team to inform an holistic health assessment. ***A letter will be sent to Public Health advising them of this matter.***

Case Example: *This case concerned an under-age young person who was the alleged victim of a sexual assault by an older person of the same sex. There was an ongoing police investigation against the alleged perpetrator.*

There was also evidence of grooming taking place whilst the young person undertook voluntary work.

There was evidence of good engagement with the CASH service, they attending for various treatments and screening. They were also on the waiting list for intervention from the rape crisis team, Southampton.

The young person was referred to the CASH outreach nurse, but as these records are kept separately we were not able to see what support has been given and if any further CSE risk assessments had been carried out.

There was no evidence of any liaison in the electronic records seen with social services or the looked after nursing team to inform early health assessment. We also saw no evidence of supervision of the case being undertaken by senior or safeguarding practitioners in the records examined.

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 Locally it has been agreed that the children's global assessment scale (CGAS) is the optimum tool to assess children and young people's mental wellbeing and it began being incorporated into statutory health assessments in Southampton during 2015.

5.1.2 There is an increasingly cohesive partnership between Southampton CCG and the local authority. The early development and establishment of an integrated commissioning unit (ICU) with a single management structure is good evidence of this, facilitating a smooth transition of commissioning responsibility of health visitor and school nurse services from the CCG into local authority public health. We heard of the commitment of the partnership to ensure that services are better aligned to support the development of the 0-19 pathway and to hearing the voice of the child.

5.1.3 The recently appointed designated nurse (Head of Safeguarding) has inherited a sound legacy from the previous post holder and is building on this. She is well regarded by stakeholder agencies and demonstrates strong leadership; taking safeguarding arrangements and practice forward in collaboration with the named GP. Southampton benefits from having a highly skilled and experienced clinician undertaking the named GP role. She is providing strong and effective leadership to primary care while working with significant capacity pressures, particularly having recently taken adult safeguarding into her portfolio of responsibilities.

5.1.4 The designated doctor for looked-after children leads the looked-after child health team with strength. She sits on the corporate parenting board, has vision and a hands on approach in leading the small team of paediatricians and specialist nurses who operate the service. She has been innovative in developing a number of bespoke templates, such as the health assessment for UASC, bespoke health plans and standard health plans for care leavers.

5.1.5 The service delivery model of the looked after children team, consisting of the designated doctor, specialist paediatricians, the named nurse and two specialist nurses, undertaking all review health assessments for young people placed in area is 'gold' standard and highly commendable, more so given the high quality of health assessments and the high number of young people in care. However, the named nurse post, the day to day operational lead, will become vacant in March 2016, reducing the capacity for review health assessments significantly. There is no contingency plan in place to mitigate the impact of this imminent hiatus. This is not on the trust's risk register, although we were told that both of these are being addressed and the trust is initiating recruitment. There is high risk that so significant a loss of capacity will impact on the service's ability to deliver the operating model to the detriment of young people ***(Recommendation 6.1)***

5.1.6 A remedial action plan has been put in place to drive improvement in performance on the timeliness of initial and review health assessments for looked-after children. Performance is monitored closely through the monthly exception reports which are sent to the performance team and head of safeguarding in the CCG. These reports are reviewed quarterly at performance monitoring meetings and are also reported six monthly to the CCG clinical governance committee. These highlight areas of concern which impede good performance such as; social worker compliance with the looked after children process regarding parental consent and submitting completed paperwork required for the health assessment to take place promptly. The establishment of the joint administrative role between Solent NHS trust and Southampton city council is indicative of partnership commitment to improving performance. The role has been instrumental in reducing the number of late notifications to health of children coming into care. It is an expectation that all looked after children will be linked into public health nurses through 'Healthy Ambition' (No Limits).

5.1.7 A very recent (January 2016) positive development is the setting up of the 'health and wellbeing of looked after children's' group. This is for all stakeholder agencies involved with looked after children. The group aims to identify what services need to understand about looked-after children and their particular needs and entitlements. It is currently shaping its agenda and identifying priority areas for development.

5.1.8 Health are well engaged with the reorganised Local Safeguarding Children Board (LSCB) structure with the chief nurse being an LSCB member and the CCG head of safeguarding (designated nurse) chairing the learning and development sub-group which, among other responsibilities, takes forward learning from local and national serious case reviews.

5.1.9 Strategic managers in both the CCG and from public health spoke positively about the strengthened governance arrangements and challenge to agencies as a result of the revised LSCB arrangements. These include a more robust focus on section 11 audits and 'deep dive' auditing.

5.1.10 The CCG report a strong working relationship between the CCG and the Wessex area team (NHS England) facilitated by their co-location and the development of common policies and strategies with neighbouring authorities such as Portsmouth and Hampshire.

5.1.11 Solent NHS Trust provides a wide range of services across Hampshire, which incorporates several local authorities. The safeguarding named nurse has a strong vision and provides effective leadership to the small team of safeguarding advisors and across services. The safeguarding advisors are skilled and committed; accessible for advice, guidance and the delivery of supervision. However, capacity in the team is significantly stretched and it is not clear to us that capacity within the Solent safeguarding team is sufficient given the span of responsibilities and key role within the MASH. ***(Recommendation 4.6)***

5.1.12 The MASH is an important and positive multi-agency approach to safeguarding children in Southampton and we saw the model working well at this point in its evolution. Health navigators operate with skill and commitment. The rotation of the navigator role is a good model of delivery for health which we have seen operating successfully elsewhere in what is often an intense environment. The high frequency of rotation of the health navigator is unusual in our experience but appropriate in supporting the small resource of practitioners in the health navigator team. In our visit to the MASH, we saw and heard evidence of occasions when lack of navigator capacity to respond to some amber cases within timescale raises the risk that health information, key to optimum decision making in the MASH, may be missed.

5.1.13 Adult mental health do not have a navigator presence in the MASH as might be considered best practice. This can result in a lack of immediate access to clinical expertise and guidance in assessing and deciding levels of risk in a case. The current protocol we were given to understand during our review is that information from adult mental health is sought by social care navigators and not by the health navigators. The reason and rationale for this was not clear to us. The health navigator could act as a helpful conduit in the absence of an adult mental health navigator, to ensure that the input from adult mental health is fully and promptly captured and its implication for the health and wellbeing of the child fully understood in the MASH which is mainly comprised of non-clinical staff. We recognise that this would put additional capacity pressure on the health navigator.

Since our inspection we have been advised that the existing MASH health navigator (Solent NHS Trust) currently sources adult mental health information from the GP. We are further advised that from May 2016, as part of the planned integration of MASH/MARAC, an adult mental health practitioner from the integrated adult mental health team (Southampton City council and SHNHSFT) will be available to provide adult mental health information from Southern Health and work with the Solent MASH health navigator to ensure that the input from adult mental health is fully and promptly captured and its implication for the health and wellbeing of the child fully understood in the MASH.

5.1.14 The Solent health visitor and public health nurse service is integrated to align with the 0-19 pathway but still in the process of transition. The intended outcome is good; to streamline services for children 0-19 and in some cases 0-25, into a single pathway so that there is ease of access and more targeted early help leading to improved outcomes.

5.1.15 Southern Health are in the middle of an improvement plan which started in May 2015 in response to concerns over a number of key performance issues. Recent changes have included adult health service redesign into three community teams and one crises intervention team. Early indications are positive.

5.1.16 The named GP for Southampton is providing a strong lead to GPs across the area in developing primary care safeguarding practice and engagement in multi-agency arrangements. In response to an identified area for development in health visitor (public health) and GP liaison, vulnerable families meetings have been established across primary care. This helps to promote effective information sharing about families known to be vulnerable and facilities their engagement with early help support.

5.1.17 The named GP regularly visits practices and works closely with the CCG head of safeguarding. Safeguarding supervision for GPs has recently been introduced in the form of lunchtime supervision forums held twice a month and is open to all GPs across the City. This has superseded the primary care safeguarding leads forum. A separate practice nurse forum has also been set up to facilitate practice nurses safeguarding practice and this is a positive initiative. We were told by the health navigator that the majority of GPs are now responding to their requests for information, engagement with GPs is improving and the introduction of the laminated flow chart which sets out the pathway for information sharing between primary care and the MASH is proving helpful to this.

The named GP however, cited difficulties in the engagement of GPs and requests for information can and do arise when social care navigators do not follow the protocol in requesting information. Further, the health navigator reports that some surgeries across Southampton are difficult to elicit information from, even when the request is made by them and in accordance with the protocol. This is unacceptable and increasingly rare for us to encounter in undertaking our reviews nationally.

We heard a case example in the Southampton MASH of an ‘amber’ case where the information gained from the GP about the mother’s recently emerging mental health issues was instrumental in this becoming a ‘red’ case and child protection processes being initiated. This illustrates sharply the importance of eliciting information, which sometimes only the GP is holding, promptly to effectively inform decision making in the MASH and is an area for development ***(Recommendation 6.2)***

5.1.18 Young people age 16 or 17 who choose to attend adult ED do not always have their details recorded on paediatric paperwork and UHS have recognised this as a challenge. There is no review or audit of all young people who use adult ED to identify where paediatric paperwork has not been used. Although adult safeguarding vulnerabilities are considered, the needs of young people are different. If safeguarding concerns are identified as part of the adult assessment then the default position is to continue on paediatric paperwork and the young person would be seen by a consultant paediatrician. However, the paediatric liaison specialist nurse does not routinely review the attendances of young people who access adult ED services. This is a gap and means that there is a risk that some young people's needs may not be appropriately identified. ***(Recommendation 2.8)***

5.1.19 There is a growing and increasingly complex safeguarding agenda in Southampton which is likely to place significant challenge on the head of safeguarding and their capacity to effectively provide leadership, governance and support. We were advised that to date the named nurse for looked-after children has not received one-to-one specific safeguarding supervision which would be expected from the designated nurse over and above generic, ad-hoc support. There remain questions about the capacity of the head of safeguarding to undertake both the designated role for safeguarding and for looked-after children, especially in respect of the current high number of looked after children. ***(Recommendation 6.3)***

5.2 Governance

5.2.1 Performance on the timeliness of IHAs and RHAs, dental checks and up-to-date immunisations has been a long-standing challenge in Southampton (see 5.1.6 above) and there continues to be inconsistency in performance as reflected in the data submitted to the CCG. Solent NHS Trust acknowledges that there is an issue of accuracy of the data being addressed with trust analysts.

5.2.2 We saw evidence of learning from local SCRs resulting in strengthening of policies and procedures an example being the introduction of a more robust escalation policy. What was less clear is how learning from national SCRs is informing the improvement of safeguarding practice in Southampton; an example of this being the routine under-recording of father's details in maternity services. This area for development was acknowledged by the chair of the LSCB.

5.2.3 The MASH referral template contains prompts to facilitate health practitioners and other professionals in making referrals which clearly articulate the risk of harm to the child or young person. There is work to do across services to ensure that copies of referrals to MASH are retained on individual client case records. This is to ensure the case record is complete, provides an appropriate audit trail and facilitates effective operational governance of safeguarding activity and practice. We heard a number of systems relating to this described to us: the referral is e-mailed on the MASH referral form, shared to the shared drive, printed and then scanned onto the case record. The system described to us in one service was that it was all the responsibility of the practitioner to ensure this was completed. This is inefficient and in busy services, is unlikely to be done. Case sampling this week has demonstrated to us that this is not being undertaken routinely and as a result we were unable to review many referrals as they were not copied onto case records. It is not clear whether the LSCB has reviewed these arrangements and practice recently. ***(Recommendation 7.1)***

5.2.4 Southern Health have appropriate structures in place to provide the trust board with assurance on safeguarding practice. However, the lack of robust key performance indicators means that there is limited opportunity for proactive identification of any emerging concerns. For example, the trust does not currently measure attendance at child protection conference, no monitoring of referrals to MASH and there is limited audit and quality assurance on compliance with safeguarding policies and protocols.

5.2.5 In UHS, the named midwife maintains a list of vulnerable mothers-to-be to monitor key dates by which action ought to have been taken in line with the LSCB protocol. In principal this process should enable effective tracking of cases but the absence of any analysis of risk and of any SMART actions means that effective, safe outcomes for the unborn child cannot be measured ***(Recommendation 2.4 as at 1.7 above)***

5.2.6 In UHS ED, the provision of the dedicated paediatric liaison specialist nurse role is considered a strength and a feature of good governance arrangements. All information sharing forms are reviewed by the paediatric liaison nurse as are the discharge notification letters. However, there is potential for the effectiveness of the paediatric liaison specialist nurse role to be undermined by the inefficiency of the systems and processes. An example of this is that although recording by ED staff is structured by clear forms, they are not supported by a fully functional IT system. There is an over reliance on the need to scan documents that are hand written and from records seen, these are often not legible, with quality being lost by the scanning processes. In the event of a child's further attendance, the previously scanned documents are the only record to give history and therefore there is a risk that records will be incomplete, difficult to read or not accessible. Lack of attention to previous history and attendances is a feature of serious case reviews. **(Recommendation 2.9)**

5.2.7 The paediatric building does not meet the needs of the service provision. The area is cramped and there are a small number of bays separated by curtains. The limitations of the current environment are well known by the trust and there are plans to move the paediatric waiting and treatment areas to a new and more acceptable building in which children can be cared for, although we recognise that there are no timescales for this presently.

5.2.8 The SystmOne IT system is new to Solent and therefore unfamiliar to a number of services. A working group is in place to support its implementation and use by practitioners, developing templates and appropriate operational policies

5.2.9 Southern Health are currently in the middle of an improvement plan which started in May 2015 in response to concerns over a number of key performance issues. Recent changes have included adult mental health service redesign into three community teams and one crises intervention team. Early indications are that the changes are having a positive impact, especially in relation to a 'think family' approach in care provision.

5.2.10 Southern health's IT system does not support adult mental health practitioners in recording details of children in households. There is also no flagging system to identify where a child in the family is subject to a plan or is being supported through child in need. These system deficits do not support the development of a clear 'think family' service model, a culture of performance management and governance of safeguarding practice. ***(Recommendation 5.2)***

5.2.11 The Southampton City clinical commissioning group clinical governance committee noted in its minutes of January 2016 that its quality report has improved and contains more information. However, it was also noted that sometimes there needs to be more information regarding providers working to actions plans, such as, actions being taken, who is responsible, and time for completion and/or timescales for updates.

5.2.12 At both the GP practices we visited during our review, we saw that systems are in place to regularly and proactively monitor vulnerable children and young people on the patient list who are subject to a child protection plan or child in need plan . At both practices we saw that this is by way of regular vulnerable families meetings where school nurses and health visitors are invited to contribute. The appointment of dedicated administrative staff to record and track all correspondence about vulnerable children and young people means that information about them is not lost, is logged and responded to in a timely way. The benefits of this are that the practice's knowledge of such children is always current and this supports good decision making.

5.3 Training and supervision

5.3.1 Midwives are trained at the appropriate safeguarding level and newly qualified midwives undergo a competency based preceptorship which supports their developing safeguarding practice well. Their induction includes particular competencies for safeguarding. The use of a buddy system is positive and ensures they are equipped to keep new mothers and their babies safe.

5.3.2 Whilst we acknowledge that the named midwife is available to provide advice and guidance on safeguarding matters to all the maternity team, we found that midwives do not currently experience robust, meaningful, scheduled and case specific safeguarding supervision. Moreover, the absence of formalised one-to-one safeguarding supervision means that midwives are not enabled to reflect on difficult decisions, not only in terms of the safety of children but also in terms of the effects on their own wellbeing. ***(Recommendation 2.10)***

5.3.3 In the FNP we saw that one-to-one safeguarding supervision is scheduled to take place on a weekly basis for each nurse. This focuses is on supporting the team member with their decision making process and ensuring their health and wellbeing. Three cases at most are discussed at each session ensuring that there is sufficient time devoted for in-depth discussion. Staff are given the opportunity to prepare in advance for supervision and this includes an assessment of the key domains of the family nurse programme (such as personal health, family and friends, environment and maternal role) in terms of their strengths and weaknesses. The session also considers the voice of the child by posing a question, 'If the child could speak what would they say about their family?' In all of the six cases we looked at within the FNP we saw that there was a clear analysis of the risks to the child. There were also specific and measurable actions agreed between the nurse and the supervisor although some of those actions were not time-bound. This indicates that safeguarding supervision is meaningful, leads to better decisions about young mothers and their children, considers the child's voice and supports the welfare of staff members.

5.3.4 In one case examined whilst reviewing training and supervision in the FNP we saw that a family had progressively disengaged with the service over a short time. This had led to a breakdown in the relationship between the nurse and the family to such an extent that the adults in the family had taken to verbally abusing the family nurse. A supervision decision led to the nurse being supported by her manager at the next child protection conference for the child where the behaviour and engagement of the family were addressed. Further supervision led to the manager supporting the nurse through the ensuing work to re-engage the family with the service. This proved to be a successful re-engagement and resulted in the family participating fully in the programme and a step-down from child protection to child in need. This demonstrated the impact of good supervision, not only on the wellbeing of the practitioner, but also on the positive outcome for this particular child.

5.3.5 ED staff at UHS are either trained appropriately to level three or working towards level three as part of an induction programme. We were told that there is a review of training currently being undertaken across the trust. In training records seen however, three nurse managers were noted to be out of date with their own level three safeguarding training. ***(Recommendation 2.11)***

5.3.6 The paediatric ward staff at UHS have not accessed any training in caring for children and young people with mental health needs or who have self-harmed. The CAMHS liaison workers provide bespoke support to the staff team who are caring for children with mental health needs on a case by case basis. Training in caring for the mental health needs of children is important as they regularly care for this group of vulnerable children whilst they are waiting for CAMHS assessment and a safe discharge plan. ***(Recommendation 2.12)***

5.3.7 Solent NHS Trust's named nurse has developed an innovative tiered model of supervision which has been introduced across trust services and ensures good supervision arrangements are in place. All health visitor and public health nurses are expected to be trained to level three safeguarding. However, in records seen the figures presently show less than 60% compliance. There has been a recent re-alignment of training which has had an impact upon the statistics. The realignment of training requirements against the intercollegiate document and roles and responsibilities is a positive move towards ensuring that staff are trained to the required standard commensurate for their professional accountability and the needs of children.

5.3.8 In adult substance misuse, we found sound supervision arrangements with good use of the Solent safeguarding children's supervision template. One practitioner we spoke with used the template as a self-assessment tool to support her safeguarding practice and continuous professional development.

5.3.9 The CASH service use a variety of methods to ensure staff are supervised and supported with complex cases. Clinical supervision takes place every four weeks on a one-to-one basis where staff can discuss individual cases of concern. Staff receive safeguarding supervision on a group basis every six to eight weeks where complex cases and their impact are discussed so that all staff can learn from them. Staff who require additional support, either with the impact of particular cases or with their decision making for such cases, can book an additional one-hour safeguarding supervision session with the trust's safeguarding team although this is not routine. In addition, the safeguarding team run a telephone advice line where staff can call and obtain ad-hoc advice and support for emerging concerns. The records of supervision, however, are not documented on client records; instead, 'discussed at supervision' is shown on the client file with detailed notes being shown on the staff file. This is not good practice as it does not support auditable decision making and prevents effective information exchange if the case is taken over by another worker. ***A letter will be sent to Public Health informing them of this matter.***

5.3.10 Adult mental health practitioners are expected to attend level two safeguarding training. Those teams who work with young people such as the early intervention team for psychoses and perinatal mental health team access level three training. Training within the trust is joint adult/child in content and has been ratified by the LSCB and the CCG. Southern health recognises that supervision in safeguarding children practice within adult mental health services is an area for improvement. Current practice is to discuss safeguarding and child protection on cases during clinical supervision, although outcomes are not recorded on service user records. There is a development programme for band seven practitioners and supervision is a key element of this.

Recommendations

1. Southampton City CCG, University Hospital Southampton NHS Foundation Trust and Solent NHS Trust should:

1.1 Work to ensure that UHAs are received and used by health practitioners to better inform the care planning process across services.

2. University Hospital Southampton NHS Foundation Trust should:

2.1 Ensure initial assessments in midwifery services include a full assessment of risk to include information held on primary care records and that this information is readily available for practitioners to access.

2.2 Put in place measures to ensure questions about domestic violence are routinely asked of expectant mothers during pregnancy and that answers are recorded. This should be subject to routine audit.

2.3 Ensure midwifery records routinely record father and/or partner details and that these details are made available on all referrals made to social services.

2.4 Maintain oversight of midwifery health plans to ensure all records are up-to-date, clearly articulate risk, record safeguarding discussions held and further that subsequent plans are SMART and regularly updated.

2.5 Ensure expectant mothers who do not meet the criteria for perinatal mental health support are signposted to other available support networks or advised accordingly.

2.6 Ensure identified risks to unborn children are fully recorded and accessible to midwives in patient records and also when making a referral to the MASH

2.7 Ensure the development and subsequent use of a CSE risk assessment tool is expedited and used within Midwifery services and the FNP.

2.8 Ensure all young people who attend the ED up to age 18 are appropriately notified to and reviewed by paediatric liaison.

2.9 Improve methods to accurately record and refer to previous attendances on the UHS ED electronic systems as opposed to the over reliance for hand written documents to be scanned onto the system.

2.10 Ensure that routine, monitored and recorded safeguarding supervision takes place within midwifery services.

2.11 Ensure all staff, including relevant managers are trained in safeguarding vulnerable children and young people as recommended by 'Intercollegiate Guidance' and 'Working Together'.

2.12 Assess the training needs of paediatric staff working on wards at UHS and, where appropriate, provide training in the psychiatric care of children placed on their wards whilst awaiting a CAMHS assessment.

2.13 Ensure the 'voice of the child' is clearly recorded on assessment paperwork to demonstrate that events had been clearly explored with individual children and young people.

3. Solent NHS Trust should:

3.1 Ensure health visitor representation is invited to attend or inform multi-agency forums to discuss pregnant women and unborn children at risk due to parental substance misuse.

4. Southampton City CCG and Solent NHS Trust should:

4.1 Monitor and review the effectiveness of multi-agency oversight in relation to practitioner attendance at, and reporting to, inform child protection conference and that outcomes from those meetings are received and recorded on client records.

4.2 Monitor and review the use of IT systems in adult substance misuse to reflect risk to children and young people and alert practitioners of that risk.

4.3 Ensure better recording of the 'voice of the child' in looked after children initial and review health assessments as opposed to quoting them in the 'third person'.

4.4 Put into place a formalised quality assurance framework to better assess the quality of both IHAs and RHAS for children and young people placed both in and out of area.

4.5 Ensure SDQ scoring is used to assist the care planning process for all looked after children and young people across Southampton.

4.6 Review and update staffing roles and responsibilities within the Solent safeguarding team to ensure there is capacity to effectively provide robust safeguarding best practice across the area.

5. Southern Health NHS Foundation Trust and Solent NHS Trust should:

5.1 Strengthen safeguarding communication links between agencies to improve liaison and information sharing.

5.2 Review methods used to record children in households, including IT client records and 'flag' these to practitioners so that they are better informed of any safeguarding risk.

6. Southampton City CCG should:

6.1 Ensure the provider has contingency planning at an early stage when it is recognised that key staff members resign recognised child safeguarding posts.

6.2 Continue to work with GPs and children's social care to ensure information sharing protocols and processes are embedded within practice to ensure effective and timely safeguarding practice and ensure that, where there are protocols in place for information sharing, then these are followed across GP practices in Southampton.

6.3 Undertake a review of designated roles in Southampton and ensure appropriate safeguarding supervision is offered by senior safeguarding practitioners and undertaken accordingly.

6.4 Ensure adult mental health practitioners routinely request and record questions and answers regarding the identity of children and young people with whom their patients have parental or carer responsibilities or who they have access to.

7. Southampton City CCG, University Hospital Southampton NHS Foundation Trust, Southern Health NHS Foundation Trust and Solent NHS Trust should:

7.1 Embed processes to ensure client records are up-to-date and that all referrals made to the MASH are recorded on those records. This should be subject to routine and regular audit.

Next steps

An action plan addressing the recommendations above is required from Southampton City 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.