

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

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

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Provider services included:	Medway NHS Foundation Trust (MFT) Kent and Medway NHS and Social Care Partnership Trust (KMPT) Sussex Partnership NHS Foundation Trust (SPFT) Kent Community Health NHS Foundation Trust (KCHT) Medway Community Healthcare C.I.C (MCH) Turning Point
CCGs included:	NHS Medway CCG
NHS England area:	South
CQC region:	South
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Summary of the review

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

Where the findings relate to children and families in local authority areas other than Medway, 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. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 88 children and young people.

Context of the review

The latest published information from the Child and Mental Health Observatory (ChiMat) (2015) shows that children and young people under the age of 20 make up 25.5% of the population of Medway. There are 20.7% of school age children from a minority ethnic group. The proportion of children under 16 living in poverty is 21.2%, worse than the England average, as is the rate of family homelessness although the rate of children in care is not significantly different to the rest of England. Infant and family mortality rates are about the same as those for the rest of England.

The ChiMat data shows that, on the whole, there is a mixed picture of the health and wellbeing of children in Medway with generally better than average opportunities for health improvement. For example, there are fewer babies with low birth-weight and fewer obese children than the rest of England whilst children have generally better dental health. There are also fewer admissions to hospital of young people due to alcohol specific conditions or substance misuse.

Conversely there is a greater proportion of children who have not received the MMR vaccine by age two and there are significantly more than average conceptions in young people under 18 and teenaged mothers. The rate of admissions to the hospital emergency department of children under four is significantly better than average as is the rate of hospital admissions caused by injuries in young people aged 15 to 24 years; whereas the rate of hospital admissions caused by injuries in children aged from birth to 14 years is significantly higher. The rate of hospital admissions for young people with mental health conditions is also significantly higher than the rest of England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at March 2015, Medway had 250 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 35 of whom were aged five or younger.

The DfE data indicates that a greater proportion of Medway's looked after children (98%) had received an annual health assessment than the average for England (89.7%). All (100%) of looked after children aged five and under had an up-to-date health assessment, greater than the England average of 89.4%. The data also showed that 92% of looked after children were up-to-date with their immunisations, higher than the England average of 87%.

However, only 56% of the looked after children in Medway had received a dental check-up as compared to the average 85.8% for the rest of England.

The commissioning and provision of health care services for children and young people in Medway is varied and relatively complex as set out below. Commissioning and planning of most health services for children are carried out by NHS Medway Clinical Commissioning Group (CCG). Health services for looked after children are jointly commissioned by the CCG and the public health directorate of the local authority, Medway Council.

Acute hospital services, including emergency care and maternity, are commissioned by the CCG and provided by the Medway NHS Foundation Trust (MFT). MFT also provide the school nursing service which is commissioned by Medway Council.

The health visiting service is commissioned by the public health directorate of Medway Council and provided by Medway Community Healthcare Community Interest Company (MCH).

Child and Adolescent Mental Health Services (CAMHS) are commissioned and provided as follows:

- Services at Tier 1 and 2 of the National Strategic Framework for CAMHS are commissioned by Medway Council, jointly funded with the CCG and are provided by a variety of emotional wellbeing services providers – we did not visit these services during this review.
- Services at Tier 3 are provided by Sussex Partnership NHS Foundation Trust (SPFT). SPFT also provide a bespoke 'Children in Care' service specifically for looked after children funded by the local authority. Both services are commissioned by the CCG.

- Services at Tier 4 are commissioned by NHS England and provided by the South London and Maudsley NHS Foundation Trust (SLAM). We did not visit this trust during our review.

Adult mental health services are commissioned by the CCG and provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

Contraception and Sexual Health services (CASH) and the Genitourinary Medicine (GUM) Service are commissioned by Medway Council and provided by Kent Community Health NHS Foundation Trust (KCHT) and Medway NHS Foundation Trust (MFT) respectively.

Adult substance misuse services are commissioned by Medway Council and are provided by Turning Point.

Child substance misuse services are jointly commissioned by NHS Medway CCG and Medway Council and provided by Open Road. We did not visit this service during our review.

The last inspection of safeguarding and looked after children's services for Medway took place in October 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for both safeguarding children and looked after children were judged to be 'adequate'. Recommendations for the providers arising from our recommendations of that review were considered during this review.

Of the NHS trusts identified above, only two have been subject to recent CQC regulatory inspections where there were findings in relation to children and young people that affect this review.

Sussex Partnership NHS Foundation Trust (SPFT) was inspected in January 2015 and there were findings in relation to the CAMHS service. Medway Foundation NHS Trust (MFT) was inspected in August 2015 and there were findings in relation to the Children's ED and staffing in the safeguarding team. We considered the findings of those inspections during this review.

The report

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

What people told us

A parent speaking about the emergency department said:

"I have to come here quite often with my son as he is very disabled. The staff here are always great, I've got nothing to complain about."

Another told us:

"They know what they are doing here. Children first always and it's so nice not to have to queue up out there (in the adult waiting area) as it can get really noisy."

We spoke with a young person who had just been seen in the department. They told us:

"I'm fine thanks. I was seen really quickly and had an X-ray. They told me everything was OK and I'm happy with that."

One young person who was a care leaver told us that he felt overall very positive with the services and support he had received on health care.

He also told us:

"The looked after children nurses are very good at listening and responding to assistance when needed for GP visits, CASH services and general health support."

And ...

"All the looked after children nurses are knowledgeable and signpost and support care leavers very well."

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 Before examining the child's journey from the perspective of the health services, it is important to understand the pathway for referral to other services at each level of intervention in Medway. This is important as it affects the liaison arrangements between health and with other agencies for each level of intervention. The agencies in Medway use the Medway Safeguarding Children Board's (MSCB) guidance known as the 'Medway Inter-Agency Threshold Criteria for Children in Need' to determine the level and nature of support offered to children, young people and their families. This guidance describes four levels, or tiers of intervention with the purpose of ensuring that children and their families have access to services that meet their needs. The four tiers are described according to the level of need.

- Universal – where there are no identified additional needs, no identified risks and assessment under the Common Assessment Framework (CAF) is not required
- Increasing Need – where targeted early intervention may be required, needs are not clear, not known or not being met and where the CAF may be used to co-ordinate support by universal services or targeted preventative services or a 'team around the family' (TAF)
- High – the 'Child in Need' threshold where high level needs are identified requiring a targeted, integrated response from children's social care and potential for 'Child Protection' to be reached
- Complex – the 'Child Protection' threshold where acute needs requiring urgent, intensive children's social care statutory support is identified.

Health services in Medway feature at each of these levels to a varying degree, whether as single agency providers of support or as part of a TAF.

1.2 Expectant women can contact maternity services directly, either on-line or through a dedicated telephone number to book their pregnancy. The majority of women book early and their GPs are contacted to ask for information intended to contribute to the risk assessment. In most cases seen, however, it was not possible to see if GPs had responded to the request for information and midwives had not documented if they had used any GP information to revise their assessment of risk. There is no assurance, therefore, that information held by primary care is fully considered and used to inform maternity care planning. [Recommendation 1.1](#)

1.3 Conversely, all mothers-to-be benefit from comprehensive screening of risk and social vulnerability. The completion of the 'Family Background Risk Questionnaire' is a useful tool in identifying and recording the father's details, the details of any additional, existing children who may be within the family or cared for by others and whether either partner has had support from, or is being supported by children's social care. In all of the files we looked at, risk assessments were always comprehensively completed. This ensures that care planning reflects social risk factors that might affect unborn children.

1.4 Expectant women are seen alone at least once during pregnancy to enable the opportunity for confidential discussion and we saw good records made of those occasions when a woman was seen alone. It is expected that an enquiry about domestic abuse should be made at these appointments; however, we could not be assured that this enquiry was being made routinely. Domestic abuse is known to increase in pregnancy and it is important that women are given the opportunity to safely disclose any concerns. [Recommendation 1.2](#)

1.5 A small but increasing number of expectant women in Medway are now being identified as having experienced historic female genital mutilation (FGM). The named midwife has seen a rise in the number of cases reported following local training and the introduction of a screening tool; this is evidence of the effectiveness of the training. The local process is being further refined with the expectation that children's social care is alerted to the presence of any female children, including a new-born female in the household of a woman who has FGM trauma where there is ongoing risk.

1.6 Where an expectant mother has vulnerability or risk identified, the case holding midwife can arrange for her care to be discussed at the maternity hub meeting. These meetings are chaired by a social work senior practitioner and have good multi-agency attendance. Notes are taken and decisions are made about how health services can best support expectant women and safeguard unborn babies. The midwifery service use a 'Concern or vulnerability' form and complete one of these for families discussed at the hub meetings. These forms are shared with the GP, health visitor and any other professional involved with the family. Expectant women can be referred for early help through these meetings and this is a strength. We have reported below under 'Child protection' on the referral route for more formal child protection processes.

1.7 Joint visiting by midwives and health visitors to expectant women is well established in Medway. This multi-agency and proactive approach to provide a co-ordinated package of support to vulnerable women is now increasingly being offered through joint visiting by midwives and children's social workers and this is positive.

1.8 Expectant women who have additional peri-natal mental health needs can be referred to a specialist, consultant-led peri-natal mental health team. Expectant women who do not meet the threshold for this service may be supported through the work of a specialist midwife in peri-natal mental health. This specialist midwife offers a range of intervention and support, from consultation with case-holding midwives through to providing full midwifery case management, thereby increasing the opportunities to mitigate any risk to unborn children. Mothers-to-be can also access the PRANX support group, an enhanced service set up by the specialist midwife to help ante-natal or post-natal women develop strategies to overcome anxiety. This support group continues to be positively evaluated by people who have accessed it.

1.9 Expectant mothers who are receiving treatment and support from the local substance misuse service are also effectively supported during pregnancy by the Windmill Clinic. This is a dedicated clinic operating one day every week where women receive specialist support from a midwife or obstetrician with a special interest in substance misuse. This further enhances the opportunity to mitigate any risks to unborn children from maternal behaviour during pregnancy.

1.10 Teenaged mothers-to-be can receive support from the Family Nurse Partnership (FNP) if they meet the enrolment criteria. For those young women that are unable to meet the criteria or who choose not to engage with the FNP, additional support is available from the early intervention and support services provided by Medway local authority.

1.11 Health visitors have received training in leading work under the CAF and frequently take on the 'lead professional' role. The health visitor role in providing early help to local families and communities is well developed. For example, joint working with staff at local children's centres is good and is effective in providing a range of well-co-ordinated early help and support. Additionally, health visiting cases we looked at showed a timely notification and handover of families who move into, or out of the area.

1.12 A specialist health visitor for domestic abuse provides strong leadership and support for the work of the health visiting workforce. For instance, there is good information sharing and engagement with the Multi-Agency Risk Assessment Conference (MARAC) arrangements. A resulting strong, shared focus on early identification and intervention in cases of domestic abuse was demonstrated in the cases we looked at.

1.13 Further, a specialist health visitor for mental health provides good guidance for health visiting colleagues by attending core groups and conferences to help support decision making. Moreover, case auditing of complex families cases had identified that health visitors require more training to help them better promote approaches to working with people with a personality disorder and this has now been addressed. As with domestic abuse, in the cases we reviewed we noted a strong, shared focus on early identification and intervention where parental mental health is an issue.

1.14 Early help and support offered by the school nursing service to families is largely limited with evidence of good practice being infrequent. In one case we saw that a school nurse had effectively and persistently engaged in work with one parent over the child's issues with enuresis and obesity and in ensuring that immunisations were up to date. This was despite some initial reluctance to engage on the part of the parent. There had been good school nursing contribution to the TAF which had led to good outcomes for this child. However, this was not typical in the cases we looked at with most records showing variable levels of engagement with young people and their families. Overall we found that the role and contribution of school nursing staff was not well demonstrated.

1.15 In our previous safeguarding inspection we highlighted issues regarding the capacity of the school nursing service to undertake work under the CAF. This was an ongoing area of challenge given the gaps in school nursing resources and their skill sets. During this review we learned that dealing with significant increases in child protection related activity has stretched the school nursing capacity to support work at the lower, child in need threshold, their early help contribution and more routine school health work. For instance, immunisation data indicates variable take-up from between 59% to over 90%. Our review of cases identified less effective engagement with new arrivals to the area and a low take-up amongst children of eastern European origin.

1.16 We saw that the lead nurse has been working to define the role of school nurses within the MFT and wider partnerships and to develop clear pathways and operating procedures. For example, a new telephone liaison form has recently been developed for use with the paediatric liaison nurse (see below) to enable consistency in information sharing and prioritisation of work. The school nursing administrators have now received training in, and have read-only access to the trust's 'Symphony' patient records system. This is very much work-in-progress, intended to strengthen links between the service and other departments in the trust, and will ultimately support identification of and intervention with children who would benefit from the service. However, much of the rest of the improvement work is still in draft form. The school nursing role and the service's contribution to early help work has therefore remained relatively under-developed since our last review. *This has been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the school nurse service.*

1.17 All children and young people who are admitted to the emergency department (ED) at Medway Maritime Hospital are reviewed by the paediatric liaison nurse. The nurse then notifies GPs, health visitors and school nurses of the child's attendance. The paediatric liaison nurse also reviews all referrals to children's social care and admissions to the paediatric ward and this ensures that children and young people are appropriately directed to relevant services once their ED attendance has concluded.

1.18 All attenders to the paediatric ED are provided with a 'Sharing information about children and young people' document. The document clearly explains MFT's responsibility in relation to safeguarding children and young people and how attendance information is shared routinely with GPs, health visiting services and school nurse services. It also sets out how information might further be shared with social services and education services should concerns be raised. Being provided with written information clearly explains the trust's responsibilities without being solely reliant on visitors to the unit reading notices displayed.

1.19 Children and young people attending the ED first have their personal and demographic details taken by a receptionist at a 'children only' area in the main ED reception which is open day and night, seven days-a-week. Children and their families are then directed to a paediatric only waiting area which is served only by staff members in possession of an appropriate electronic key. This ensures that all visitors to the unit can be appropriately screened before admission but also ensures staff members are aware of all people leaving the unit.

1.20 Although the reception area is separated from the adult area we learned that plans are at an advanced stage to move the paediatric reception area to a location inside the paediatric waiting area. We spoke with the parents of children waiting for assessment who told us that they appreciated being able to wait with their children in an environment more appropriate to them and thus reduce stress and anxiety. The incorporation of the reception into the paediatric waiting area will enhance this already positive child-focussed environment.

1.21 Conversely, however, there is no separate provision for young people aged 16 to 17. Instead, they are currently directed to the adult ED. This potentially vulnerable group do not receive care and treatment either in the paediatric ED or in discrete facilities that are age-appropriate. This limits the choice of young people to be seen by staff who are more attuned to their needs. For example, young people in mental health distress who require a mental health assessment are seen on the paediatric ED by a Child and Adolescent Mental Health Service (CAMHS) practitioner up to the age of 16. This leaves a potential service gap for those young people aged 17 who are currently assessed in the adult area and practitioners we spoke with acknowledged this. [Recommendation 1.3](#)

1.22 ED practitioners told us of the positive impact of access to on-site CAMHS practitioners seven days-a-week. Although not yet available 24 hours-a-day the facility means that children and young people with acute mental health needs are seen and assessed at the earliest opportunity, even if admitted out-of-hours at a weekend. This has had a positive impact on young people attending the ED because it means they do not routinely require admission to a ward unless absolutely necessary. CAMHS practitioners can promptly direct children and young people to alternative services with the minimum of delay.

1.23 As well as providing this strong 'front door' service in ED, the CAMHS service has a 'duty room', which schools and young people themselves can call in order to talk to someone to help manage any anxiety. In support of this, the service has taken steps to educate staff in other agencies who might be called upon to support young people or to refer them onwards as appropriate. For example, we learned of a programme of training and advice provided by the CAMHS service to staff in schools to ensure they understand the thresholds and are able to support young people who might be anxious whilst awaiting treatment.

1.24 Young people in Medway who are using the CAMHS service further benefit from a clear pathway to support their transition to adult services from 17 and-a-half years of age. Recently improved communication and liaison between the two trusts that provide the CAMHS and the adult mental health services have meant that the transfer of care from one to the other is subject of a managed plan driven by the young person's needs.

1.25 Outreach workers from the contraception and sexual health (CASH) service carry out regular visits to schools, the local college, youth clubs and also occasionally to local night clubs to offer sexual health advice including *chlamydia* screening. This is a proactive initiative and ensures that young people can receive support and advice at a time and place that is more convenient for them and enables them to be better engaged. For example, we spoke with a young people's advocate who works in one of the larger senior schools in Medway. The advocate told us of some excellent protracted work by one of the CASH service outreach workers with two young people in a relationship where there was a notable age difference; work which lead to the young people having a greater understanding of the risks to their sexual and emotional health.

1.26 Children and young people who attend the genitourinary medicine (GUM) clinic at the Medway Maritime Hospital are quickly identified and seen as a priority before other waiting clients by one of three senior clinical staff with safeguarding expertise. In this way their treatment is expedited so that their waiting time in an adult environment is kept to a minimum and their sexual health is assessed in the context of their age related needs.

1.27 The adult substance misuse service has developed a 'Resolution Clinic' which has positive take-up by working adults and parents with alcohol related stresses. This provides early help with drink related stress management by offering six health and wellbeing sessions to promote safer drinking and alcohol reduction. The clinic has been effective in attracting parents or adults with access to children and who have drink related problems that might otherwise be reluctant to ask for help until they are in crisis.

1.28 We learned that, although there has been some improvements, the effectiveness of communication between GPs and other health providers about children and families is variable. There is currently no, single, robust established system for discussing the needs of vulnerable children with other health practitioners. For example, whilst we saw that there was opportunity for health visiting teams to share information with GPs about children through health visiting hubs, this was on an *ad hoc* basis. There are no scheduled meetings or exchanges with other health providers that take place consistently across primary care and this is a missed opportunity to ensure that early help and support that meets the needs of vulnerable children and families is properly co-ordinated. *This has also been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the health visiting and school nurse service.* [Recommendation 2.1](#)

2. Children in need

2.1 The health visiting service is appropriately engaged with mothers of young children and works closely with them to strengthen parenting capacity through regular monitoring visits and effective joint working with other services.

A mother and her 17 month-old child who was developmentally delayed was supported by a health visitor as part of a child in need plan. There had been a number of strategy meetings held in relation to repeated concerns about neglect but the circumstances had not yet reached the threshold for child protection work.

During her work with the family, we saw that the health visitor had identified concerns about maternal mental health even though these issues had not been acknowledged by the mother. The health visitor had also been vigilant in recognising the signs of 'disguised compliance'. The health visitor had employed strategies to improve the parenting capacity of the mother and the physical wellbeing of the child. This included providing guidance about the benefits of interacting with the child through play and a referral of the child to physiotherapy to address delays in development of gross motor skills.

The case records showed that this had had a positive impact even though this was dependent on the mother's continued mental wellbeing. The health visitor continues to undertake regular monitoring visits to ensure that the mother addresses issues with her parental capacity in a sustainable way.

This was a typical example of strong, family focused work by the service that we saw throughout our visit.

2.2 We saw evidence of good joint working between health visitors and midwives with an effective notification process for identification of vulnerable families and sharing of information of concern.

In another case we saw an example of effective work by the health visitor in promoting attachment to a new baby and of taking prompt action to co-ordinate and heighten concerns raised by other health colleagues that resulted in an escalation of the case to child in need.

2.3 As with the health visiting service, the Family Nurse Partnership (FNP) has been similarly effective in Medway in reducing risk of harm to unborn babies and supporting young parents in recognising risk and building their parenting capacity. We saw an example of good preventative work with a 16 year-old young pregnant woman who is subject of a child in need plan who is due to give birth soon. This case showed good joint working with the CAMHS service to address serious trauma experienced by this young person. Her mental and emotional wellbeing is now more stable and, through direct work by the FNP in relation to bonding and understanding the vulnerability of her baby, she is looking forward to parenting her child.

2.4 We learned from a member of the hospital's safeguarding team that relationships with both GPs and school nurses are good and that they effectively engage in sharing information to protect vulnerable children and young people. However, despite the evidence we saw of effective work in the health visiting and FNP teams with their existing clients, the safeguarding team reported that the relationship with health visitors is not as well established. Referrals made to the health visitors are not generally accepted for children who are not subject to child protection plans, who are not children looked after, or who are not receiving support from the FNP or not currently known to the health visiting service. This suggests that those children at the periphery of care who do not meet child protection criteria can be overlooked and potential risks not acted upon. Whilst we did not see any direct evidence of this, it is important that both MFT and MCH explore if there are any existing barriers to exchanging or acting on information about children that emanates from attendances at ED. *This has also been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the health visiting service.* [Recommendation 5.1](#)

2.5 The CAMHS service has a psychiatric liaison facility up to 11pm in the ED and on-call coverage through the night. Therefore, as reported above under 'Early help', children who attend ED who are at risk due to their mental health or emotional wellbeing have access to a specialist service when they most need it. The CAMHS crisis home treatment service means that young people also have access to an intensive treatment pathway and this is a strong offer.

2.6 The tier three CAMHS service provided by SPFT have recently taken on elements of the management and clinical leadership of the tier two service provided by the local authority. The trust also directly employs some mental health professionals who are based within this part of the overall service. This means that the tier two service has been strengthened by the additional professional and specialist mental health expertise of staff in the tier three service. Additionally, this further move towards an integrated service means that young people who may need to be stepped up or down to a different level of intervention can do so in a more co-ordinated way.

2.7 The single point of access to the CAMHS service means that young people in need of support can be properly assessed by a joint tier two and tier three team in a timely way and directed to the most appropriate level of intervention. Once referred onwards for tier three work, a further level of assessment by a multi-disciplinary team enables the selection of the most appropriate pathway that best meets the young person's needs. Children who are supported on the tier three pathways are further, regularly reviewed by the multi-disciplinary team in order to adjust their treatment or to discharge them as necessary. This is a robust process and ensures that young people are treated on the most relevant pathway for their needs and do not remain in treatment beyond what is appropriate.

2.8 We are aware that historically, the waiting times for treatment from CAMHS have been poor and that there has been a significant improvement in those times. However, the staff acknowledge that there is still work to do to maintain this improvement and ensure children are consistently seen in good time.

2.9 In cases we reviewed in the adult mental service we saw good evidence of the 'Think Child' approach to practitioners' work with adult service users and professional curiosity about client's families. The staff approach to this showed strong professional curiosity, despite the IT system in use in the service not being well enough configured to identify children or prompt staff to identify children in families. [Recommendation 3.1](#)

2.10 Relationships between adult mental health teams and the midwifery hub are improving. However, there is still the potential for expectant women who are already receiving adult mental health services not to be accepted by the peri-natal mental health team and communication across the three services is an area that could be strengthened.

2.11 In the adult substance misuse service we saw a clear focus on children living within the family of clients, at home or elsewhere, from first point of contact with the service. Clients' initial assessments routinely include the ages of children and whether a safe storage box has been provided or refused and this forms a key element of risk management plans. Substance misuse recovery workers are mindful of the needs of children and young people, particularly those in caring roles, and have forged links with local carer organisations to strengthen a range of support available to the wider family. For example, a young person's advocate we spoke with told us that whenever the service have a client who has children, a referral to the children's substance misuse service is facilitated to ensure that the child or young person is supported to manage the impact of the parental substance misuse.

3. Child protection

3.1 Midwives can refer expectant mothers to children's social care any time after 16 weeks into their pregnancy. A pre-birth assessment protocol guides children's social care and midwifery services on key milestones around assessing and planning child protection processes. To date there has been no multi-agency audit on compliance with the protocol, but the named midwife reported that discharge planning meetings at 36 weeks into the pregnancy were increasingly more timely.

3.2 Where risk to unborn children is identified midwives can call the social care single point of access known as the Contact and Advice Service (CADS) to discuss their concerns through a telephone consultation with a social worker. In some instances, individual cases can be brought by the case holding midwife for discussion at the weekly maternity hub meetings in the same way as we have reported above under 'Early help'. In all cases midwives complete a 'Concern or vulnerability' form to record the details of the concerns in preparation for discussion.

3.3 The examples of the forms we looked at, however, showed that details are completed with little articulation of risk, simply stating the reason for making the referral. Further, the purpose of these forms is to guide discussion and not to create a joint, agreed record of the referral and it is not practice to routinely send them to the CADS as part of the referral record chain. Moreover, we learned that cases discussed at the maternity hub meeting are not accepted or declined as referrals by children's social care at that meeting but that midwives are directed to 'call-in' the information once more the following day for a telephone consultation with the CADS. In this respect, the only referral route open to midwives is by way of telephone consultation. There is no shared record of the referral save for an 'outcome' letter sent to the referrer once the case has been looked into, and generally some days or weeks later. Such letters contain summaries of the referral, the action taken and the result or outcome of the case. This is problematic for the professional practice of the midwives and we have discussed the issue in more depth under 'Governance' below.

3.4 In all files we looked at, we saw evidence that that midwives attend child protection and core group meetings and submit a written report. Midwives are expected to complete a written template on the outcome of any child protection or child in need meeting, share this with the named midwife and ensure a copy is in the record. This ensures that the patient file is up to date with the most recent and relevant information and is good practice.

3.5 Expectant mothers whose babies will be subject to child protection arrangements benefit from plans that clearly articulate the arrangements for the birth and post-natal period. These plans are shared with the mother and copies kept on the labour and post-natal wards. Alerts are flagged on the patient electronic record so that other practitioners are aware of potential risks.

3.6 There is a clear expectation that where the plan is for babies to be removed from their birth mothers, they should not be subject to extended hospital stays. The named midwife continues to meet with her counterpart in children's social care to work towards reducing the number of these untoward incidents. Good liaison between midwifery services and the looked after children health team ensures that all information is shared with the team as soon as the decision is made to remove a baby and once the baby is born. A form has been designed to ensure best practice in capturing all relevant health information to assist in arranging a sympathetic but safe removal of the baby into the care of children's social care.

3.7 There was good engagement by health visitors in safeguarding work on all child protection and child in need cases we looked at. The attendance and contribution to conferences and the quality of reports to conferences is good.

One case we saw in the health visiting service showed effective joint working by the health visitor with the mother to enable her to take action to protect her baby by addressing her experience of being abused. This has strengthened her parenting capacity, enabling her young child to feel more secure emotionally.

3.8 The referral process is well managed by the health visitors being well-prepared. Following case consultation, health visitors type up their analysis of the areas of risk, their role and contribution and where they require assistance from social care. This supports joint decision making about managing serious concerns. However, as with other services we visited during our inspection and commented on elsewhere in this report, written feedback provided by social care is limited.

3.9 The role and contribution of school nurses to child protection work is not sufficiently clear at an individual and wider family level. For instance, the school nurses have limited contact with the children's social care referral processes as most referrals are made directly by the schools; we noted that only two referrals had been made by the service in the last three years and this is unexpectedly low. Further, the role of school nurses in the delivery of direct support to children at risk of harm, including children at risk of child sexual exploitation (CSE) is not sufficiently developed. For example, one case showed good joint working between CAMHs and ED and sharing of information with the school nursing service. However, the school nursing role and the contribution to child protection planning was not well defined. There was a lack of focus on the risks to children or an exploration of how the school nurse could support the plan.

3.10 The reports submitted by school nurses to child protection conferences provide only limited information about children's health needs. There are a number of gaps in key areas, particularly in relation to commentary on the parenting capacity, family and environmental factors as well as an overall lack of holistic focus on child's identity, emotional and mental wellbeing. This limited contribution is exacerbated by the perception of a lack of value of the school nursing role to child protection processes. This is evidenced by requests for information from children's social care which are largely focused on health checks, with little attention to wider health needs.

3.11 One case we looked at showed persistence and diligence of an individual school nurse which resulted in bringing concerns about potential fabricated or induced illness to the attention of social care. There was good co-ordination by the nurse of information about a wide range of health risks to ensure concerns were clearly identified and understood by social care. However, this was an isolated example of good practice in the cases we looked at in the school nursing service. *We have drawn these shortfalls in the school nursing service to the attention of Medway Council's Public Health Directorate as the commissioner of the service.*

3.12 To date, adults who attend ED have not routinely been asked about their parenting status, even those adults who attend with risk taking behaviours such as self-harm or substance misuse. There is a reliance on the professional curiosity of staff to obtain these details but in records we looked at it was not evident that these important questions were asked.

3.13 However, on the same day of our inspection, improvements to the electronic reception procedure means that all adults will now be asked a simple question; 'do you have parental or carer responsibilities?' A 'yes' answer will prompt the assessing health practitioner to ask further questions about children and record answers accordingly. As the system was only being implemented whilst we were on site we could not test its effectiveness. [Recommendation 1.4](#)

3.14 Paediatric admission paperwork for young people aged 16 and over attending ED is not routinely used and there is a risk that key information about the young person might not be captured. In one case we looked at, it was not clear if ED made any referral to children's social care for support of a 16 year-old girl who sought treatment and disclosed pregnancy, even though there was a known history of self-harm, severe depression and involvement with CAMHS. The adult ED record used does not show any systematic assessment of safeguarding risks. [Recommendation 1.5](#)

3.15 Further, women who attend ED and who are pregnant or who are accompanied by or have access to children are not routinely asked questions about their risk of being subject to domestic abuse. For example, we reviewed one case of a 17 year-old young woman who attended the unit and disclosed she was in the early stages of pregnancy. She had complained of potential problems in the pregnancy but was discharged without an enquiry being made or recorded about the risks of potential domestic abuse that might have contributed to her attendance. [Recommendation 1.6](#)

3.16 Although we saw that children attending the ED have parent or carer details generally well recorded there is no format or template to record sibling details, even when safeguarding concerns are raised about the presenting child. A mix of both paper records and the 'Symphony' electronic records system means that safeguarding questions can be missed. The absence of a mandatory process for asking those important questions before moving on to another part of the admission process means that the identification of risk is largely reliant on professional curiosity. [Recommendation 1.7](#)

3.17 The 'flagging' system on the 'Symphony' records in ED is not robust and does not sufficiently identify risks, such as known child protection risks, self-harm or domestic abuse. This was a feature of our safeguarding and looked after children inspection of 2011 and was subject to a recommendation then, as well as comment in a recent regulatory inspection in 2015 but this has not sufficiently improved. We were made aware that individual practitioners can add specific markers to the system if thought necessary but this is not policy and is not routinely applied. Staff members can get access to limited social work information through the social care database, 'Framework I', but this is currently restricted to just children from the Medway local authority area. Furthermore, it relies solely on overt action by the practitioner to research as opposed to a systematic notification or alert and there is a risk that it will not be done. [Recommendation 1.8](#)

We saw a number of good practice examples of staff professional awareness and understanding in ED.

For example, we reviewed the case of a mother who attended by ambulance in mental health distress and who disclosed that she had four children before leaving the unit without being treated. An understanding of the risk and quick thinking by the staff resulted in the children being located by the police and subsequent referrals being made to children's social care.

In another case we saw that the parents of a young baby had disclosed that they had left their child alone at the hostel in which they were staying. The parents had been out and were then involved in an incident necessitating attendance at the ED. Staff alerted police and the child's safety was confirmed by them. A subsequent referral to social care and communication between the paediatric liaison nurse and health visitors helped to ensure the child was protected and that appropriate support was in place.

3.18 Referrals made to children's social care for children who are identified as being at risk are treated in the same way as those made by the maternity service. In this case, a 'Paediatric emergency department children's social care referral' form is completed with details of the child, siblings, parents, GP and a short section to describe the reason for referral. As with the form used by the maternity service there is little scope for a full articulation of risk; it is simply used as the basis for discussion with the CADS and subsequently forwarded to the trust's safeguarding team. As with the midwifery service, the only referral route into children's social care is by way of a telephone consultation and there is no shared record of the referral. The trust's internal form is subsequently only used to record the outcome of the referral some time later when the outcome letter is received or, in some cases, when it has been chased. Once again, we have discussed the referral process in more depth under 'Governance' below.

3.19 We have reported above in 'Children in need' on the effectiveness of the CAMHS single point of entry and multi-disciplinary assessment in meeting children's needs. We also found that this structure allowed practitioners to consider risk to children and young people at each of the key decision stages. We saw evidence of the risk to patients' safety being assessed during initial entry to the service through the single point of access and then assessed again during the multi-disciplinary 'Choice and Partnership' meetings when the appropriate pathway was selected. In addition, the electronic patient record system used in the tier three service supported good risk assessment through the use of templates and appropriate flags to alert staff to ongoing risks. In the cases we looked at we saw that risk assessments and action plans derived from them were detailed and of a good standard. However, the absence of timescales for carrying out actions meant that the ability to track or monitor progress was limited. [Recommendation 4.1](#)

3.20 The CAMHS service uses the Medway Safeguarding Children Board's CSE toolkit and these documents are uploaded onto the system as part of patient records. In addition, the service has two CSE champions so that staff have access to advice and guidance. In the cases we looked at we saw that assessments were comprehensive and clearly articulated risk with plans to mitigate such risk.

3.21 In common with other health providers, the CAMHS service has only one referral route into children's social care and that is by way of telephone consultation. There is no separate pro-forma used by CAMHS staff to record the details of the referral; however, detailed notes are kept on the electronic patient database. In the cases we looked at we saw that there were comprehensive notes about the reason for the referral including a full articulation of the risks to the child and this is expected good practice.

3.22 The absence of a shared record of the referral, however, is also a cause for concern among CAMHS staff who reported that there was a risk for information to be misinterpreted and this was borne out in our review of cases. For example, one case we sampled related to a young person who had been physically assaulted (struck) by a parent during an altercation. The clinician's record was completed in detail and explained the risks as they related to the young person's mental health and the effects of the assault on their emotional wellbeing. A subsequent entry in the record showed that the information had been shared with children's social care and that an outcome letter would be sent in due course. The outcome letter, dated some two weeks after the information was shared, was brief and stated that the issue related to the young person 'pushing the boundaries'; there was no mention about the assault or any explanation about how it had been investigated. As previously stated, we have commented on this arrangement in 'Governance' below.

3.23 The impact of adult mental health on the emotional health and wellbeing, and in some cases the physical safety, of a child is well documented in serious case reviews. Case records we looked at showed that adult mental health practitioners are not invited to child protection strategy meetings and that when referrals are made to children's social care they do not always receive an outcome letter summarising the concerns and outcome. Given the absence of a shared record made at the point of referral we could not be assured that the impact of adult mental health had been considered sufficiently by children's social care at the point of referral in the cases we looked at.

3.24 For example, in one case we sampled we saw that the father of a child had been deemed a protective factor in relation to the risks arising from mother's mental health when the family had been assessed earlier in the previous year. Escalating concerns over the child's safety arising from the mother's deteriorating mental health and threats to harm the child had been referred to children's social care later in the year but the referral had been declined owing to the continued presence of the child's protective father. In this case, the lack of shared documentation arising from discussions meant that it was difficult to understand the rationale for the decision not to accept this as a child protection referral.

3.25 Named nurses from KMPT attend initial child protection conferences to support adult mental health practitioners to bring consistency and an understanding of the local area's 'strengthening families' model of conferencing. This also helps adult mental health practitioners to identify their role in core groups. However, the report template that practitioners complete has not been updated to reflect the strengthening families approach and this does not help practitioners to articulate their thoughts in preparation for the conference.

3.26 We saw good examples of detailed record keeping in the progress notes in adult mental health patients' electronic records and this demonstrates a good underpinning safeguarding culture. However, there is an over reliance on staff members to report important information in this way where it is not easily searchable and there is potential that risk might not be isolated or updated. [Recommendation 3.1](#)

3.27 We saw evidence of good engagement of adult mental health practitioners in protecting children in formal child protection processes. However, risk assessments and care plans were not always being updated and there was an over reliance on the aforementioned progress notes. This makes it sometimes difficult to establish quickly what the most up to date situation was within a family where there had been a need to safeguard a child. Additionally, chronologies and genograms are not routinely used to help practitioners understand complex families and significant events. [Recommendation 3.2](#)

3.28 Cases we looked at in the CASH service showed that a paper based safeguarding assessment is used effectively and supports good decision making about young people at risk, although the text entry fields on the form are small and do not allow great detail. All young people under 16 are automatically assessed in this way as are any 17 and 18 year-olds where there are concerns. Where risk is identified we saw that a further CSE toolkit assessment is carried out. Comprehensive narrative records are made in the clients' records detailing action taken, including where referrals are made to children's social care.

3.29 The CASH team are invited to child protection initial and review conferences. We were advised that the service is rarely asked for a written report and we saw no evidence of such reports on the cases we looked at. Instead, the case worker or a deputy attend conferences and provide a verbal input only. Where child protection conference invitations are received these are automatically forwarded to the trust's safeguarding team who are available to support where necessary.

3.30 In the GUM service, as well as being fast-tracked and seen as a priority, each young person also benefits from the completion of a CSE risk assessment. This assessment uses a well-established nationally available template. Any concerns identified are passed to the named nurse and if necessary referred onwards straightaway to social care.

3.31 Team membership of the adult substance misuse service, Turning Point, includes a social worker whose caseload focusses on families where there are children aged three years and under. This practitioner works closely and effectively with midwives at the Windmill Clinic (see above under 'Early help'). This ensures regular contact and information sharing in relation to risks and relapse.

We looked at the case of a woman who was pregnant and who was previously a looked after child. The woman had had a previous child removed due to her misuse of drugs and alcohol and mental ill-health. The father of the child in the unborn baby also had a history of domestic abuse.

Over a period of seven months the Turning Point caseworker worked with the midwife to ensure the safety of the unborn baby and to re-engage the mother whenever she relapsed. Work with her involved a comprehensive and assertive range of activity in relation to regular monitoring of her progress and regular review of her treatment plan to minimise harm to the unborn baby. This included positive, interim working with the mother through attendance at the 'Recovery Skills' workshop offered by Turning Point.

This case showed a high level of intensive work and persistence by Turning Point to engage the pregnant mother with effective joint working and information sharing with the specialist midwife. This enabled the building of a clear shared strategy that aligned her residential detoxification programme with plans for the delivery of her baby and the post-natal period.

3.32 In the GP practice we visited, we saw that a robust system is in place to monitor the needs of children and young people at risk by way of weekly scheduled meetings between the GPs, clinical staff and a member of staff designated as safeguarding administrator. The safeguarding administrator's role is to ensure all correspondence about children who are looked after or who are subject of child protection or child in need plans is logged, scanned into the practice system and that this information is discussed by the practice team at the weekly meetings. This is a strong internal process but we are unable to say whether this is a consistent practice across GPs in Medway as our inspection was limited to a visit to just one practice.

3.33 In the GP practice we visited we saw that information sharing takes place with the health visitors at the practice meetings although the same arrangements are not in place for school nurses. However, we were advised that this is not a consistent arrangement across Medway. The named GP reported that communication between GPs and the community health teams was variable and not as robust as it ought to be. As well as being a missed opportunity to co-ordinate early help and support, it also limits the capability of GPs and other key health professionals to manage the care of those who are most at risk. *This has also been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the health visiting and school nurse service.* [Recommendation 2.1](#)

3.34 We learned that GPs in Medway rarely attend child protection conferences in person but that all practices submit written reports. There is no conference report format for GPs to use so the quality and extent of information provided is variable, with some GPs writing letters and others simply printing patient records. This means that, in many cases, information about children at risk and their families is not interpreted for conference or presented in a format that supports effective decision making. [Recommendation 2.2](#)

3.35 We were advised that GPs routinely make referrals to children's social care through the same route as other health providers; a telephone consultation with the CADS. However, in order to ensure an accurate record is made of the consultation and of the reason for the referral, some GPs use a pro-forma, based around the questions used in the managed conversation with CADS, to help them to prepare for the discussion. This form is then scanned into the patient's record and we saw evidence of its effective use in the practice we visited.

4. Looked after children

4.1 In our review of cases in the looked after children service, we found that some initial health assessments contained exemplary notes on the health of birth family members. This is important information which helps to inform the child's ongoing health needs through their experience of care and beyond, and young people often tell us how important family information is to them in their adult lives.

4.2 Whilst this important information is well recorded in the initial health assessments we looked at, it was not present in, or had been considered as part of the review health assessments. In addition, where initial health assessments did not contain family health detail, some children were still in contact with family members and so there was still an opportunity for professionals to obtain this important information.

4.3 Health plans produced following initial health assessments and health reviews are good. Clear accountability and due dates for actions are present in all plans we looked at. Specialist nurses review all plans following initial and review health assessments to check on progress. This is helping to ensure the health needs of children and young people in care are prioritised.

Child X came into the care of the Medway local authority at the age of 13. The initial health assessment identified a number of significant health needs, such as the need for assessment by an optician and by a dentist; support to help her sleep and for her weight management; urgent referrals to CAMHS and to a urologist.

These health needs had previously been unidentified. This example illustrates the way an effective initial health assessment can have a positive impact on meeting and improving the health of children coming into care and was typical of the cases we reviewed during this visit.

4.4 Children and young people coming into care benefit from an initial health assessment carried out by a community paediatrician. The looked after children team closely monitor performance to ensure that initial assessments are carried out within 28 working days of a child coming into care. Any breaches in performance are investigated and reported on in a regular performance report.

4.5 Review health assessments are carried out by the looked after children specialist nursing team, including the lead nurse. Most review health assessments we looked at reflected the 'voice of the child'. Where it was age appropriate, signed consent had been obtained from the young person.

4.6 An increasing majority of children and young people engage with their health assessments and health reviews. Good efforts are made by the specialist nurses to contact those young people who refuse to attend their appointments. Where appropriate, the nurses complete the assessment paperwork and share this with the designated doctor. This is effective in ensuring that health needs continue to be assessed and identified even with those young people who are not ready to actively participate.

4.7 Good effort is also made in ensuring that health assessments and reviews are informed by as much health related information as possible. Processes are in place to ensure that children's social care are asked if they are aware of any relevant health information to share with the looked after children health team prior to the date of the review. GPs are routinely asked to contribute to assessments and they are always provided with a copy of the final health plan.

4.8 Children and their carers benefit from completing 'Strengths and Difficulties' questionnaires (SDQ). Outcomes from SDQs are shared with the looked after children health team. We saw evidence that showed how high scores are used to inform the reviews and to support referrals to local specialist looked after children psychological support or CAMHS. Scores are not currently compared from one review to the next; this would be a good opportunity to track any progress or deterioration in a child or young person's emotional health and wellbeing.

4.9 Children and young people looked after benefit from agreed care pathways that provide additional support. Specialist nurses support young people in getting access to outreach CASH and substance misuse services and remain vigilant to any triggers for CSE.

4.10 The CASH service are directly engaged with the looked after children service, including the care leavers nurse, and have bi-monthly meetings. The service is tasked directly by the looked after children nursing team to provide one-to-one support and advice on sexual health to young people in care and will often carry out joint visits with the looked after children nurse to individual young people. This is a positive and proactive approach that benefits the sexual health of looked after children in Medway.

4.11 Arrangements to provide asylum seeking children with robust and timely initial assessments are an area for development which is recognised locally. The number of young people who do not turn up or where the interpreter did not turn up to facilitate the assessment also remains an area of concern. The looked after children health team are very much attuned to the recent, extreme increase in unaccompanied asylum seeking children due to pressures elsewhere in Europe and further afield. We saw that they are actively in discussion with local partners to try and improve the local offer. For example, during our visit we saw a presentation on unaccompanied asylum seeking children by the looked after children designated nurse to local GPs during one of their protected learning time sessions. It was heartening to see that immediately after the presentation a number of GPs volunteered their services to assist in the growing requirement for health assessments for such children.

5. 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 In general, we found that safeguarding in Medway's health services had strong strategic direction and a shared focus from a committed, learned and proactive leadership team across the CCG and the providers. There are some issues with resourcing which we will describe later.

5.1.2 The North Kent Safeguarding team is a collaborative arrangement between three neighbouring CCGs, one of which is Medway. The team share resources and designated professionals across the three CCGs, including two designated safeguarding nurses and a looked after children designated nurse. The designated doctor is employed by MFT but carries out the role under a service level agreement with the CCG. The team has links with the Medway Safeguarding Children Board (MSCB), the Health and Wellbeing Board and Medway Council. The team also provides support and direction for the safeguarding functions of the health provider organisations that cover Medway. In the main, this is achieved by a steering group for safeguarding activity in the region known as the North Kent Safeguarding Committee.

5.1.3 The CCG told us they felt the designated nurses are a strong team that work well across all areas and with a positive impact on the providers. This was borne out during the week of our review where we saw plentiful evidence showing how the CCG team had supported the named professionals in the health provider organisations. Named professionals spoke positively about the support offered by the CCG designated nurses.

5.1.4 Part of these arrangements are the quarterly named professionals clinical network meetings, chaired by the designated doctor, which guide and support safeguarding work in Medway. Examples of the proactive work of the safeguarding clinical network include: A current issue for clarity on the use of the pre-birth assessment pathway between the maternity unit at MFT and children's social care; a workshop to develop a 'did not attend' (DNA) pathway for providers which is soon to be implemented.

5.1.5 This proactive strategic direction and leadership from the CCG designated team was further substantiated by the public health commissioners for the local authority. They said they had found the CCG always had capacity to support the provider services with improvements. For example, they told us that the CCG's work to promote understanding of CSE across all health services was of great benefit; the general uplift of knowledge in this area is something we also noted.

5.1.6 The named midwife at MFT does not have adequate support to enable her to discharge her responsibilities in a proactive way. There is no dedicated administrative support and although the trust have supported the named midwife by providing *ad hoc* support through periods of staff secondment this has not been continued. As a consequence, audit in safeguarding practice is underdeveloped within maternity services and therefore the trust cannot be assured that best practice is consistently being applied. [Recommendation 1.9](#)

5.1.7 As with the named midwife, the MFT named nurse and safeguarding team are under resourced having lost, and not replaced two of five staff members. This has resulted in a drop in capacity of the team to manage safeguarding across the trust effectively. For example, we learned that there was a significant backlog of filing and a lack of capacity to chase children's social care for outcome letters to referrals. This reduced capacity of the team means that there is little opportunity to proactively monitor quality and so performance cannot be assured. [Recommendation 1.9](#)

5.1.8 In addition, the paediatric liaison nurse has recently reduced her working hours to three days-a-week and there is currently no cover for Thursday, Friday, Saturday and Sunday. Urgent cases can be reviewed by the safeguarding team during these hours but they are generally reviewed by the paediatric liaison nurse on her return on Monday. This means that the trust is not in a position to review all admissions to the ED or paediatric ward other than those considered at some risk. The role is currently being recruited to but in the meantime there is some risk that not all admissions or referrals to social care will be appropriately reviewed in a timely way. [Recommendation 1.10](#)

5.1.9 The health visiting team within MCH benefits from a strong safeguarding culture and good organisational processes for safeguarding. As reported above, relationships with other health services and with the local authority are mostly strong. The safeguarding team is comprised of two named nurses and these are co-located with the health visiting and family nurse partnership teams, thus ensuring that safeguarding remains a priority in the work of those teams.

5.1.10 A new health visiting to school nursing transition pathway has been recently developed and will work to ensure a better handover of children who require ongoing support although the impact of this has not yet been evaluated. There are some obvious challenges in terms of joint working given that health visiting and school nursing services are provided by different organisations and this work should have some central oversight by the public health commissioners.

5.1.11 We noted a number of areas for development in the school nursing service, some of which have already been commented upon in the foregoing sections. The areas in which we noted shortfalls in respect of leadership and management are set out in the following paragraphs:

5.1.12 The school nursing service is provided from two different locations in Medway (as well as in the neighbouring CCG area in Swale). The service has not had strong leadership until recently with much improvement work still required to bring practice and systems up to date. The lead nurse has been working to define the role of school nurses within the trust and wider partnerships and to develop clear pathways and operating procedures, but much of this is still draft. As a result, the school nursing service lacks visibility within the acute trust and there remains a significant improvement agenda.

5.1.13 Audits of practice have not taken place; for example, record keeping, reports to conferences, impact of training or supervision. There is no established culture and no system in place for assessing the quality of work undertaken or outcomes for children. As a result, quality assurance and governance in the service is under-developed and lags behind expected standards of professional practice.

5.1.14 The school nursing case records are paper based and do not provide a clear picture of children health needs or risks to their safety and wellbeing. Information sharing with the wider trust and partner agencies is significantly hindered by lack of access to, or alignment of school nursing with partner agency records. There are no firm plans yet in place to support the modernisation of the process.

5.1.15 The school nursing links with local GPs is inconsistent and dependent on local arrangements. The lead nurse spoke of one practice that held safeguarding meetings that school nurses were invited to. The overall experience, however, is of variable degrees of liaison with GPs. This is largely due to the absence of a shared approach between GPs and the service across the area

5.1.16 School nurses have high caseloads and there have been challenges in filling key posts and engaging suitably qualified staff with a range of expertise. This is being addressed but progress is slow. We noted that a knock-on effect of the school nurses being stretched is the heavy reliance on health visitors taking the lead in safeguarding work in families where there are older children. *These shortfalls have been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the school nurse service.*

5.1.17 Inter-departmental meetings have just commenced within ED. The meetings are planned to take place every month and will include a consultant paediatrician, the senior sister, an ED consultant, paediatric liaison and the designated nurse for safeguarding. Various issues will be discussed including plans to discuss pathways for children aged less than one year-old who attend the unit following a fracture. There are plans to invite a CAMHS representative to the meetings as well as social services. This is a positive step.

5.1.18 The adult mental health service provided by KMPT has appropriate arrangements in place for the trust board to be assured about safeguarding practice. There are three named nurses with one named nurse dedicated to domestic abuse and this represents a strong safeguarding team. The named nurses have responsibility for geographical areas across the trust and work proactively by going into the teams to monitor, promote and support safeguarding work. There are additional safeguarding champions within each of the operating 'pods'.

5.1.19 The safeguarding team are effective at monitoring performance and directing improvements. For example, figures for attendance at child protection conferences stood at 58%. As a result of some monitoring activity and direct work by the safeguarding team attendance has now risen to 90%.

5.1.20 We learned of an initiative involving one of the CCG's designated nurses and the domestic abuse specialist named nurse at KMPT. This involves work with the local police to help drive up awareness of domestic abuse. In support of this and the 'Think Family' agenda, the trust has re-designed their patient records database safeguarding page and they are hopeful that this work in progress will show improvements at the next audit. Although the impact of this is yet to be evaluated it will doubtless be of real benefit to safeguarding children who live with domestic abuse.

5.1.21 The CASH service has recently introduced laptops for the outreach sexual health nurses so that records of contacts with clients can be made contemporaneously. In the electronic records we looked at we saw that detailed notes had been recorded and risk taking behaviour had been well documented. This was a significant improvement on the previously used paper records where some of the risks were superficially recorded. We are aware that the electronic system used by the service is evolving and that further improvements will support better record keeping.

5.1.22 The GUM service use an index book in order to monitor the referrals they make to social care and to ensure that the response from social care is received. One of the cases we looked at in the GUM service had resulted in some joint agency learning and a helpful agreement with the Sexual Assault Referral Centre (SARC). This agreement means that, whichever agency sees a young person first, the CSE risk assessment tool completed at that first intervention is sent onwards to the counterpart agency. This is good practice as it ensures vulnerable and anxious young people do not have to repeat answers to the same questions more than once.

5.1.23 The substance misuse service, Turning Point, has new managers and safeguarding systems are being reviewed and strengthened. We saw that the service is starting to network with wider partner organisations; however we have highlighted a need for links with GPs to be strengthened. *This has been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the substance misuse service.*

5.1.24 Turning Point has recently become a member of the weekly MARAC meetings. This is helping to strengthen understanding of the risks in relation to people misusing substances who are perpetrators or victims. Their involvement is valued by other agencies in pulling together a holistic focus on risk and of actions being taken to protect children. Turning Point also has a strong system in place to ensure children living in households where substance misuse is a feature are clearly identified with appropriate oversight of these cases by the agency's safeguarding lead.

5.1.25 We were advised that safeguarding arrangements across primary care in Medway are generally effective but that the practice is variable. We were only able to visit one GP practice during our visit and so cannot confirm this assertion. However, in the practice we visited we saw that engagement in safeguarding management was robust and effective. For example, there were long standing dedicated administrative arrangements whereby one staff member records and tracks all correspondence about vulnerable children and young people with dedicated work time set aside for this purpose. This ensures all information is flagged, logged and responded to in a timely way.

5.1.26 An adequately resourced and effective team of specialist looked after children nurses is well led by the lead nurse. The lead nurse has been successful in ensuring that awareness of the needs of looked after children is an integral part of local healthcare service provision. The team are good advocates for championing the needs of this cohort of vulnerable children and young people. We were impressed by how well embedded multi-disciplinary care pathways were. There is strong liaison between the looked after children health team and other services that work to support looked after children and care leavers in accessing appropriate healthcare.

5.1.27 The looked after children health team have identified their ongoing priority areas for development; these include a more robust protocol around responses to missed clinical appointments and to make sure that children are not routinely discharged from services because of non-attendance.

5.1.28 The lead nurse for looked after children is a nominated CSE trust champion and actively monitors any looked after children identified as being at risk. These young people are discussed at the local CSE risk panel in order to direct individual work with the young people and to support multi-agency efforts at combating CSE locally.

5.2 Governance

5.2.1 As we have reported above, the CCG designated nurse team are at the heart of governance arrangements for safeguarding in the health services in Medway. There are clear and strong lines of accountability within and beyond the North Kent Safeguarding Team from CCG executive leadership through the designated nurse team and to the provider organisations. The CCG monitor safeguarding performance of each of the health providers by way of regular reporting on safeguarding quality metrics. These are designed to measure achievement at performance indicators that demonstrate effectiveness at key operational standards for safeguarding. These include parameters for attendance at child protection conferences, referrals made, safeguarding training compliance and supervision.

5.2.2 Health providers' safeguarding performance is also monitored through the bi-monthly clinical quality review group (CQRG) meetings that the CCG hosts in respect of each provider. Each CQRG meeting has safeguarding as a standing agenda item where the latest performance metrics are discussed. In this way the providers' senior or executive level leadership are sighted on current safeguarding issues and can take action as appropriate.

5.2.3 Clearly the CCG have worked hard to raise the profile of safeguarding and get safeguarding into the mainstream quality assurance work for providers. During the course of our review we have been encouraged by the strong safeguarding culture in health organisations. Most providers have internal safeguarding processes and safeguarding committees that meet with varying frequency. For example KMPT meet bi-monthly whereas MFT have just begun monthly safeguarding meetings.

5.2.4 The CCG is well represented at the Medway Safeguarding Children Board (MSCB) and its sub-groups. For example, one of the designated nurses chairs the MSCB 'Case File Audit' and the 'Lessons Learned' sub-groups for the MSCB. The work of one group directs the work of the other, such as some current, ongoing work in relation to the use of the CAF and mental health. The same is true for provider organisations with named professionals taking an active part in the MSCB sub-groups.

5.2.5 We have commented above on the poor resourcing of the safeguarding functions across the MFT acute and maternity services. We note that the CCG have also identified a number of systemic issues within the trust's safeguarding teams, principally related to this lack of safeguarding resource. The CCG are actively working with the trust on a directed improvement plan, through the CQRG and the trust's Director of Nursing with executive responsibility for safeguarding, to ensure that these shortfalls in the safeguarding team's capacity are remedied. This is still work in progress. [Recommendation 2.3](#)

5.2.6 There has been, historically, a significant gap in children on waiting lists for CAMHS. We understand from the CCG that the SPFT are aware of the work they still need to do and have seen this reflected in the candid section 11 Children Act audits submitted by the trust. However, we have noted that since the appointment of the current named nurse for safeguarding there has been a significant improvement in waiting list compliance from 20% to around 80% and this is encouraging. The CAMHS contract will finish in 2016. We noted that the current retendering process is causing some uncertainty about the future configuration of the service among the staff we spoke with.

5.2.7 We saw that KMPT safeguarding committee run a well-developed programme of audits to ensure that adult mental health practitioners contribute effectively to the protection of children in families of their clients. For example, we saw audits in relation to the way that care plans reflect child protection plans and whether crises plans identify children in families and how these children are protected. Audits have identified areas for development and the team are putting together improvement plans to address deficiencies in practice.

5.2.8 In the looked after children service, robust quality assurance processes are in place to ensure consistency in the completion of initial health assessments and health reviews. The lead nurse quality assures all assessments undertaken out of area and returns these to the originator whenever they do not meet the required standard. However, her ability to enforce changes to poor assessments is sometimes hampered by the current system for payment for such work which is not linked to performance.

5.2.9 The looked after children health team have responded positively to the recommendations of the previous safeguarding and looked after children review carried out in 2011. Healthcare summaries are now provided to all young people leaving care, the numbers of young people who engage with their initial or review health assessment has consistently improved and outcomes from completed SDQs are used in health reviews. This is positive and demonstrates a real commitment by the looked after children team to improve health outcomes for children in care.

5.2.10 Children and young people are regularly asked to give feedback to the service on their experience of the initial health assessment and health reviews and ways that the service could improve. We saw evidence of how suggestions by children had influenced delivery of the service; for example, extra clinics in the South of the area are to be provided to minimise travelling as a result of just such feedback.

5.2.11 We learned that the role of the looked after children designated nurse is soon to be subject of some internal restructuring across the Kent CCGs with a change in location and line management accountability in two different CCG areas outside the North Kent region. The current arrangements for managing the looked after children service in Medway are strong. However, it is not clear how the planned changes will impact upon the leadership and governance of the service for Medway in terms of the capacity to provide the same level of support to the looked after children health nurses in MFT.

5.2.12 It should be noted at this point, however, that we learned there is no looked after children services annual report for 2014 to 2015. This is a weakness in the CCG's and the trust's ability to determine the level of resources required for this service going forward, particularly given the increasing demands on the service caused by the increase in unaccompanied asylum seeking children in this last year.

5.2.13 The most significant issue we have to report on from our visits to services during our review is the relationship between health practitioners and social care at the 'front door'. We learned very early in the week about the operating model of the Medway Contact and Advice service (CADS). This model requires that written referrals are not accepted and the process is governed by the outcome of a managed conversation between the referrer (who is termed an 'information giver') and the social care call taker. Thereafter, a summary of the concerns are agreed verbally and the information is either accepted as a referral or not, in which case the caller may be signposted elsewhere.

5.2.14 There is an expectation that the caller will make a record of the conversation in their own systems, (either handwritten or electronic) and that this will be subject to the quality assurance mechanism in the referrer's organisation. The social care call taker makes a record in the local authority's 'Framework I' system. At the conclusion of a subsequent assessment, or some time after further work is carried out, the CADS send an outcome letter to the referrer summarising the gist of the concerns and apprising the referrer of the outcome.

5.2.15 There is no shared, written record of the referral and there is no agreed template or format used to support a consistent interpretation of the referral thresholds. We have found in our safeguarding reviews elsewhere that, where such multi-agency templates are in use, practitioners from all agencies are confident that they can identify and articulate risk in a consistent manner. Further, communication is clear and unambiguous at the point of referral through the exchange of an accountable record. It is important to note that, in Medway, we found different health services using different formatted records to note the details of the information passed to CADS in this way; for example the different versions of the same form used in ED and in Maternity and still another form used by GPs.

5.2.16 Throughout the course of our visits during the week we met with staff from different providers, who have, mostly without exception, expressed concern about the inability to follow-up verbal referrals in writing. The process has left them feeling unable to meet their professional responsibilities about record keeping and good safeguarding practice. There are many concerns that staff have with this process. These are, principally, the limited accountability for assessments or decisions made by health staff, the opportunities for information to be misinterpreted or go missing and the frequent absence of an outcome letter to apprise them of the result of enquiries. We have found examples of this in the case sampling we have carried out throughout the week and this illustrates that the concerns of health staff are not without foundation. It is to their credit that health staff have generally, maintained good patient records where they have passed on information about children at risk or in need.

5.2.17 We have also learned that both the CCG and the health providers have previously raised concerns about the model and have engaged in discussion with the local authority about its implementation. However, the CCG have been unable to locate a record of the further discussions on this beyond the initial records that set out the concerns so we cannot see whether the concerns were resolved.

5.2.18 We are also informed that the MSCB have agreed the process although both the online procedures and the short guide (the 'Blue Leaflet'), both of which were updated in October 2015, stipulate that referrals must be followed up in writing by the referrer within 48 hours using a 'referral form'. [Recommendation 2.4](#)

5.3 Training and supervision

5.3.1 All midwives and maternity care assistants are expected to access safeguarding training at level three of the intercollegiate guidance. Newly qualified midwives meet the named midwife where they receive a session on safeguarding within midwifery services. In addition, all midwives, as well as all other practitioners working in MFT who would ordinarily meet the criteria for level three training, are now issued with a 'passport to learning'. The passport supports level three training and helps to embed theory into practice. This is a competency based framework where each midwife is expected to provide evidence of compliance and achievement. We think this is a creative way of supporting level three training and we are interested in seeing the results of the pilot.

5.3.2 Arrangements to support safeguarding supervision in midwifery at MFT are robust. Regular supervision sessions are made available to midwives and we saw evidence of safeguarding being discussed in the cases reviewed. In addition, midwives are expected to provide regular updates on all cases where vulnerability has been identified.

5.3.3 The named midwife is able to access group safeguarding supervision provided externally to all named professionals and has regular training at level four through attendance at annual conferences, the most recent event being about FGM.

5.3.4 One-to-one safeguarding supervision arrangements in MCH that were introduced in September 2015 are thorough and support a clear and effective focus on the experience and risks to children. The analysis undertaken has resulted in a strengthening of the role and contribution of health visitors to supporting local safeguarding arrangements. Staff value the opportunity to reflect on their practice including joint work with partner agencies to secure better outcomes for children.

5.3.5 Named safeguarding professionals in MCH have good access to safeguarding supervision which is independently commissioned by MCH for them and this is a strong arrangement.

5.3.6 Safeguarding children training is given a high priority in MCH. A programme on domestic abuse, known as 'Safe Enquiry' training, has been rolled out to frontline staff in the last year. Practice requirements in the identification and management of risk were effectively met on cases we looked at. There is also a positive learning model in place in MCH to promote learning from serious case reviews. Health visitors also benefit from a positive initiative of joint training with social workers which enables better understanding of each other's professional roles and accountabilities. MCH acknowledge though, that CSE is an area where they need to further explore their role and accountabilities in supporting wider partnership work to safeguard children

5.3.7 We found a strong and well-developed preceptorship programme for new health visitors. This has been effective in building the confidence, competence and knowledge of recently qualified staff. Health visitor safeguarding champions are effective in strengthening safeguarding practices and supporting the continuous professional development of their peers.

5.3.8 Safeguarding supervision in the school nursing service is weak and disjointed. There is limited evidence of its impact in skilling up staff and helping to support improved outcomes for children. For example, one-to-one supervision records provide simply an overview of the issues of concern within the household, but lack clear analysis of the risk to, and voice of the child within the process. Actions are mostly incomplete or provide only a basic outline of the role and accountabilities of the school nurse, such as child measurement and immunisations.

5.3.9 School nurses have completed their level three safeguarding training in line with intercollegiate requirements. However, there has been limited follow-up to date to check the impact of training in helping to drive improvements in practice including work to protect children from CSE. *These shortfalls have been drawn to the attention of Medway Council's Public Health Directorate as the commissioner of the school nursing service.*

5.3.10 The current arrangements for paediatric ED practitioners to receive effective safeguarding supervision are not sufficiently robust. Advice and guidance is available from the safeguarding team as-and-when required but there is no formal process in place. Any supervision that does take place is not monitored or recorded. Actions arising from advice given are likewise not appropriately recorded in patient records. [Recommendation 1.11](#)

5.3.11 ED managers do not have a clear system in place to maintain oversight of individual practitioner training levels and if that training has or is about to expire. Individual staff training records have to be accessed as opposed to their being an easily updated training database to facilitate effective oversight. Furthermore, safeguarding training within the paediatric ED requires review and clarification. All practitioners on the paediatric ED are trained internally and do not benefit from multi-agency safeguarding training provided by the MSCB or with a multi-agency component. [Recommendation 1.12](#)

5.3.12 Although CSE and FGM training is available for staff members we could not be assured that this forms part of the current single agency training package. Practitioners we spoke with advised us that although they are aware of risks associated with CSE and FGM they would not know how to refer cases other than via their own safeguarding team or social services. They were aware, for example, of the newly formed CSE forum but did not know if they could directly refer cases to it or what its purpose was. [Recommendation 1.12](#)

5.3.13 The CAMHS service has safeguarding link practitioners in each of their hubs. The teams are further supported by the trust's safeguarding team so that staff can get access to specialist expertise to help with safeguarding decision making.

5.3.14 Safeguarding supervision in CAMHS is strong. Link practitioners are trained safeguarding supervisors and hold quarterly group supervision sessions to enable case debriefing and learning lessons. Staff also receive monthly clinical one-to-one supervision where safeguarding is an embedded separate agenda item for each session. In addition staff receive pastoral and well-being support during bi-monthly managerial supervision. The named nurses see all safeguarding supervision forms and records of discussions and actions are shown on patient records.

5.3.15 The CAMHS staff receive level three training delivered by the trust's safeguarding team in classroom based sessions on a rolling programme alongside practitioners from elsewhere in the trust. For example, the trust have just concluded a programme of multi-disciplinary training in CSE and are currently running 'Prevent' training.

5.3.16 The CASH service use directly observed practice and case note review by peers as a means of assuring good practice. This is beneficial as it also ensures good practices are shared.

5.3.17 The CASH service has trained safeguarding supervisors who provide two mandatory group supervision sessions each year and with a plan to introduce a method where supervisors facilitate each other's team's sessions. Further, advice and guidance is provided to staff on an as-and-when basis and where this occurs we saw that good records were made of those discussions. Staff who are identified as having dealt with a difficult case are offered one-to-one supervision; however this is reliant on such cases being identified by the practitioners themselves. We learned that this one-to-one medium had not been used in Medway even though we are aware that staff have managed cases where young people have been at risk and would ordinarily benefit from intensive support with those cases through such regular, scheduled sessions. [Recommendation 6.1](#)

5.3.18 Level three training is provided for all CASH staff who interact with children and young people. This comprises face to face multi-disciplinary classroom session provided by the trust's safeguarding team and is governed by the trust's quality assurance and training recall process. The service has ensured that all of its staff have received training in FGM, in CSE and in 'Prevent' to enhance the opportunities' for staff to identify harmful situations for young clients.

5.3.19 All members of the GUM team are trained to level three and safeguarding supervision is provided to team members by one of the three senior members for every safeguarding case managed or received. In addition the three senior members hold regular peer discussions on safeguarding cases and this is a strong method of ensuring staff wellbeing and support for decisions.

5.3.20 In the substance misuse service monthly one-to-one supervision takes place, which includes a focus on safeguarding issues. Safeguarding supervision and reports to conference could be strengthened through stronger analysis of risk and on the parenting capacity of parents.

5.3.21 Adult mental health practitioners who work in front line practice with families are all trained at level three in safeguarding children. Named nurses for KMPT have attended level four safeguarding training and are responsible for delivering the level three programme, in-house, to KMPT staff.

5.3.22 Supervision within adult mental health services is recognised by the safeguarding team as needing improvement. Although supervision does take place it is often informal and there is a plan in place to introduce a supervision template which will be completed after every session. The expectation will be that the practitioner will then enter a summary of the session and next steps onto the patient record. [Recommendation 3.3](#)

5.3.23 The CCG designated nurse, the looked after children designated nurse and the named GP provide regular level three training to GPs through monthly protected learning time events. Recently, training has included FGM, CSE and issues facing unaccompanied asylum seeking children (a session that we observed during our review). This training involves case review and facilitated peer discussion and supports the online level three component that GPs are required to complete in advance.

5.3.24 We learned of a multi-agency immersive learning event, hosted by Medway Council for the MSCB which was aimed at GPs, practice nurses, police and social workers and designed to enable practitioners to learn from real time decision making. The early feedback on this was very positive. Although this is a creative initiative for level three training, there is no data available on take-up so its effectiveness cannot yet be judged.

5.3.25 The lead nurse for looked after children has not accessed level four training in safeguarding children. Named nurses are expected to attend level four training as required in the intercollegiate guidance. Supervision arrangements for the lead nurse and the specialist looked after children nurses are robust and delivered by appropriately trained practitioners. [Recommendation 1.13](#)

5.3.26 The looked after children health team are well engaged in the training of foster carers. Sessions are provided on child development, sleep, the emotional health and wellbeing of looked after children, medicines management. Sessions have been evaluated positively by foster carers who clearly benefit from the team's input and in feedback have articulated the difference it has made in how they support their children. The team have not yet extended an offer of training on the health needs of looked after children to the wider health community because of capacity but recognise this could be an area for development.

Recommendations

- 1. Medway NHS Foundation Trust should:**
 - 1.1. Implement a process in the maternity unit to ensure that information from GPs is captured, recorded and taken account of to inform maternity care planning.
 - 1.2. Issue guidance to staff to ensure that an enquiry is routinely made of expectant women about the risks of domestic abuse and that this enquiry is noted in the patient record.
 - 1.3. Take steps to ensure young people aged 16 and 17 are assessed and treated in age-appropriate surroundings that are separate from the adult ED.
 - 1.4. Ensure that the newly introduced procedure for making enquiries about children of adults who attend ED are well embedded into practice so that there are more opportunities to identify children at risk.
 - 1.5. Ensure that paediatric admission documentation and templates are routinely used, as opposed to adult paperwork, for all young people up to the age of 17 to ensure that key safeguarding information is identified and acted upon.
 - 1.6. Ensure that women who attend ED who are pregnant, including those who are young people under the age of 18, or who have access to children, are routinely asked about risks of domestic abuse so that risks to children can be better assessed.
 - 1.7. Introduce formatted or template questions in to an early, fixed point in the ED booking-in or triage process for children so that safeguarding information can be identified at each stage the assessment and treatment process. This should include prompts to make enquiries about siblings of children for whom risk is identified.
 - 1.8. Implement a flagging process on the 'Symphony' patient record database that allows safeguarding information about children to be brought to the attention of ED practitioners by way or an automatic alert throughout each stage of the ED pathway.
 - 1.9. Undertake a review of the resourcing of the named safeguarding nurse and the named safeguarding midwife, their functions and their teams to ensure they are properly resourced.
 - 1.10. Ensure the paediatric liaison role is sufficiently resourced to enable effective oversight and follow-up of admissions of children and young people to ED and the paediatric ward.

- 1.11. Implement an effective programme of safeguarding supervision for paediatric ED practitioners that supports staff learning from active cases.
- 1.12. Ensure paediatric ED practitioners have opportunities to access to multi-agency safeguarding training at level three, and also training in FGM and CSE.
- 1.13. Ensure the named nurse for looked after children receives level four safeguarding training.

2. Medway CCG should:

- 2.1 Develop a system that supports GPs to routinely share information about vulnerable children and their families and other community health providers so that their health needs are co-ordinated across services and so that risks are effectively managed.
- 2.2 Develop a report format for consistent use by GPs in providing information to child protection conferences in a way that helps delegates understand risks to the health of children subject of the conference.
- 2.3 Maintain the impetus behind the work with MFT to ensure that the trust's safeguarding improvement plan is achieved.
- 2.4 Undertake an audit of the cases referred to CADS to determine the impact of the current referral model and use the findings to inform further discussions on the model with partners.

3. Kent and Medway NHS and Social Care Partnership Trust should:

- 3.1 Implement a template on the patient electronic database to ensure staff are prompted to consider as part of their risk assessment children to whom clients have access so that the 'think family' impact is not solely reliant on professional curiosity.
- 3.2 Ensure that practitioners who are taking part in child protection conferences and core groups update risk assessments and chronologies that reflect the progress of the case.
- 3.3 Implement an effective programme of safeguarding supervision for adult mental health service practitioners that supports staff learning from active cases.

4. **Sussex Partnership NHS Foundation Trust should:**
 - 4.1 Ensure that action plans arising from risk assessments contain timescales to enable effective completion of the actions to be monitored.

5. **Medway Community Healthcare Community Interest Company and Medway NHS Foundation Trust should:**
 - 5.1 Undertake an audit of referrals made by the paediatric liaison nurse to the health visiting service to determine if there are any barriers to information being shared or to children being accepted by the health visiting service for follow-up action following discharge from ED.

6. **Kent Community Health NHS Foundation Trust should:**
 - 6.1 Ensure the current safeguarding supervision arrangements include regular, scheduled, one-to-one safeguarding supervision sessions for the CASH service that supports decision making and staff learning from active cases.

Next steps

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