

# **Review of health services for Children Looked After and Safeguarding in Wokingham**

# Children Looked After and Safeguarding

## The role of health services in Wokingham

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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Wokingham. 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 Regional Teams.

Where the findings relate to children and families in local authority areas other than Wokingham, 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.

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## About the review

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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.

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 69 children and young people.

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## Context of the review

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The majority (88.3%) of Wokingham residents are registered with a GP practice that is a member of NHS Wokingham Clinical Commissioning Group (CCG).

Published information from the Child and Maternal Health Observatory (ChiMat) for 2016, shows that children and young people under the age of 20 years make up 25.4% of the population of Wokingham with 27.8% of school age children being from an ethnic minority group.

Although data is not available for five indicators due to low numbers, the health and wellbeing of children in Wokingham is generally better than the England average, significantly better for 23 of the 27 applicable indicators. These include children under 16 living in poverty, the rate of conceptions in young people under 18, young people's hospital admissions due to alcohol and substance misuse and children's attendances at A&E.

The data shows that the health and wellbeing of children is not significantly different to the England average for any of the 27 applicable indicators including infant and child mortality, children in care immunisations and children killed or seriously injured in road traffic accidents.

The Department for Education (DfE) provides annual statistics of outcome measures for children continuously looked after for at least 12 months. As at 31 March 2015 the DfE reported that Wokingham had 50 children who had been continuously looked after for at least 12 months (excluding those children in respite care). The number of children aged five or younger who had been looked after for at least 12 months in Wokingham is not available due to low numbers.

The DfE data indicates that 90% of Wokingham's looked after children received a dental check-up, which is better than the average for England at 85.8%. 60% of looked after children had received an annual health assessment which is significantly worse than the England average of 89.7%. The percentage of children whose immunisations were up to date was 80% which is similar to the England average of 87.8%.

Commissioning and planning of most health services for children are carried out by Wokingham CCG, either independently or as part of the Berkshire West Federation which encompasses Newbury and Community, North and West Reading, South Reading and Wokingham CCGs.

Commissioning arrangements for looked-after children's health are the responsibility of Wokingham CCG. The Royal Berkshire NHS Foundation Trust provides the designated doctor for looked after children. Berkshire Healthcare Foundation Trust provides the designated nurse for looked after children, the designated doctor for safeguarding children and the named doctor for safeguarding children.

Acute hospital services are provided by Royal Berkshire NHS Foundation Trust (RBHFT), who also provide maternity, community paediatrics and iCASH services. RBHFT also provide the Named Doctor, Named Nurse and Named Midwife for safeguarding, and Designated Professional for Child Death.

Health visitor and school nursing services are commissioned by Public Health and provided by Berkshire Healthcare Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Public Health and provided by Royal Berkshire NHS Foundation Trust.

Child and adolescent mental health services (CAMHS) and adult mental health services are provided by Berkshire Healthcare Foundation Trust.

Child and adult substance misuse services are commissioned by Public Health and provided by Starting My Active Recovery Today (SMART).

The urgent care centre is commissioned by Bracknell and Ascot CCG and provided by OneMedicalGroup.

The last inspection of safeguarding and looked after children's services in Wokingham took place in July 2010 (published in September 2010) and this was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children and the services for looked after children were judged to be 'adequate'. Recommendations from that inspection are covered in this review.

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## The report

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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.

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## What people told us

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We heard from a new parent on the maternity ward. She told us: "I have received lots of help from my midwife in the Poppy Team, she has been really supportive and I can talk to her about anything". She continued: "All the staff have been really great, I feel as though I have been looked after and helped by people who really want to do a good job".

We heard from a number of foster carers about their experience of the looked-after children's service.

One carer said: "I am kept very well informed. Just recently the looked after children nurse contacted me before the review to ask if I had anything to input as the young person preferred to go to the review alone".

Another told us:

"Recently I have had more contact with the looked after children nurse. They had a discussion with me before doing the most recent health assessment to see if there was anything specific I wanted them to be aware of, and then they contacted me afterwards to make sure we give the same advice to the young person which was really helpful. They have also chased up the actions that came from the health check to make sure all the appointments have been made".

When asked about the accessibility of looked after children's nurses one foster carer told us:

"They are very good. If they are not at the end of the phone then I only have to leave a message and they always call me back. They are consistent too, not always changing. It's important for the young people as they build up a certain level of trust over time. The looked after children nurses even share mobile phone numbers with them so they can get in touch if they have any worries".

Another told us: “In the past we have had trouble getting hold of anyone for advice when we needed it; our phone calls just weren’t returned. But recently the nurses are much more available and approachable”.

We were also told:

“I never have to chase for anything. It’s easy to get all the information I need, the looked after children nurses are very supportive and always around to either give or offer help and advice”.

When asked if looked after children receive prioritised services in Wokingham one foster carer told us:

“I think so, yes. Although they never tell you the children are being prioritised they always seem to get seen very quickly, even by GPs. It’s a very good service and I have no complaints about them at all”.

Another said: “(Child’s name) was seen very quickly by a CAMHS duty worker and signposted to counselling services”.

Foster carers also told us about their experience of the health visiting service.

One told us: “The health visitor has been really good with one of my foster children, we have had loads of contact, and she comes to the house which makes life easier”.

One foster carer summed up their recent experience of the service by saying: “Working together really does work”.

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## The child's journey

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

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### 1. Early help

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1.1 At the Royal Berkshire NHS Foundation Trust emergency department (ED) we saw good joint working and information sharing between the emergency department and the paediatric ward to ensure children are admitted in a timely manner. We noted that there is a clear system of handover in place ensuring that appropriate safeguarding information is transferred between departments.

1.2 All young people under 16 who present at ED with mental health issues are admitted onto the paediatric ward and are followed up by child and adolescent mental health services (CAMHS) on the same day if presenting before 5pm or the next working day if presenting overnight. A daily meeting takes place between CAMHS staff and ward managers to identify whether there are any ongoing mental health needs whilst the young person remains on the paediatric ward.

Recent training and guidance has been provided by a CAMHS consultant to ED and ward play staff, on how to effectively communicate with children and young people, help them feel safe and how to share any concerns they may have. This has resulted in good attention being paid to the role and contribution of the play staff in communicating with children and a strengthening of their focus on the emotional and mental wellbeing of children.

1.3 General Practitioners (GPs) are receiving notifications from the emergency department following a child's attendance, and these generally contain sufficient information. However, we were informed that when a child or a young person attends with a fracture, important information such as the mechanism of injury is not always made clear in the discharge summary. As some injuries may have resulted from lack of home safety equipment or poor parental supervision for example, this is a missed opportunity to help GPs identify families who would benefit from early intervention, help and support. (**Recommendation 3.1**)



- 1.4 At Royal Berkshire NHS Foundation Trust the small specialist team of midwives for vulnerable women take case holding responsibility for high risk cases. They share care with the community midwives for medium risk cases and are available to advise and support midwifery colleagues with low risk cases. We saw good evidence of their role in single and multi-agency liaison which helps ensure that vulnerable women are well supported and receive co-ordinated services throughout their period of care.
- 1.5 There are no formal arrangements for midwives to attend regular vulnerable family meetings with GPs or health visitors. Instead, a copy of the booking paperwork is forwarded to a woman's GP and health visitor to notify them of a pregnancy and any potential concerns identified at that point. Further information sharing takes place through the use of a second liaison form which is completed and shared at 34-36 weeks. This updates the GP and health visitor on any current vulnerabilities or safeguarding issues. (**See recommendation 1.1**)
- This information sharing helps professionals work together to ensure women who have been identified as in need of additional support can have their needs met. In the absence of formal meetings it is important that the processes in place to share information are followed. However, the 34-36 week liaison form had not been completed in all the maternity records we sampled. (**Recommendation 2.1**)
- 1.6 We were informed that all families in Wokingham should be offered an antenatal visit from a health visitor. However due to limited staff capacity within the service this is not always possible. Antenatal assessments are important as they create an opportunity to identify and assess needs, as well as intervene and provide early help to families who require it. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**
- 1.7 Within the antenatal care plan in the maternity department, pregnant women are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or other personal matters as recommended in NICE guidance. We noted that women are seen alone on an opportunistic basis. This variable practice means that not all women are consistently given the opportunity to discuss sensitive issues in private, so the midwife can identify where additional support may be beneficial to women or families. (**Recommendation 3.2**)
- 1.8 Research widely recognises an increased risk of domestic abuse beginning or escalating during pregnancy. In notes we sampled in the maternity department the recording of routine enquiry about domestic abuse was inconsistent. Therefore, we could not be assured that processes are being followed to support the identification of women who are experiencing domestic abuse. (**Recommendation 3.3**)

- 1.9 The named midwife appropriately attends vulnerable women's meetings and Health and Social Care liaison meetings, which helps ensure up to date information is appropriately shared across services involved with vulnerable families.
- 1.10 It is essential to share information which may assist professionals in ongoing risk assessments during the pre and post-partum period. We saw within the maternity department records evidence of good liaison between midwives and other health professionals such as sexual health, substance misuse and mental health services. We saw robust mental health assessments and plans in maternity records and this helps professionals identify risks to the unborn child at an early stage.
- 1.11 There is an established perinatal mental health service available to clients in Wokingham. Practitioners state they have good working relationships with health disciplines and multi-agency partners across Wokingham including social services, midwifery, health visiting and school nursing. This was evidenced consistently in the maternity and health visiting records we reviewed.

We saw how the perinatal mental health team supported a client and her family when she developed physical complications during pregnancy and had to stop taking her psychiatric medication. It was quickly recognised that she was in need of intensive care and support as her mental health deteriorated. The perinatal mental health practitioner liaised closely with the woman's GP during this time, especially in relation to the reduction and subsequent withdrawal of medication, and also increased contact with the client to almost every other day. Pre-birth planning meetings were attended on a regular basis and communication between health and social care was seen to be very close.

Attention was also paid to the needs of older children in the family who might have become neglected during this period and when the woman's partner became physically unwell, support was also provided to him.

Following on from the successful delivery of her baby, the perinatal mental health practitioner continued to work with the mother and family to protect and support them all. There was clear evidence of the very positive impact of the work undertaken with the family as a whole in this case.

- 1.12 Families and children under the age of five in Wokingham benefit from effective delivery of the healthy child programme. The two year development reviews are currently not integrated; but we were informed that the assessment information is shared with the nursery setting in order to help inform the child's education assessment. It is important that professionals are working together to review development needs of this age group, as it is a key time when specific problems may begin to surface.

- 1.13 The emergency department's discharge pathway supports health visiting colleagues to follow-up relevant attendances. All children attending ED who are under one year of age, all attendances following a head injury or accidental overdose, and any children subject to a child protection (CP) or child in need (CiN) plan are notified to and followed up by the health visiting team. For all other child attendances at ED, a notification is sent, reviewed and triaged by the duty health visitor. However, where there are no reported concerns, information relating to the attendance is not routinely logged onto the electronic patient health records. This is a missed opportunity to help ensure that health visitors maintain oversight of families they are working with. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**
- 1.14 In cases we sampled, health visitors are documenting contact with families and children in detail on the electronic patient health records. However, plans following visits are not always outcome focused or specific, measurable, achievable, realistic and time-based (SMART). This makes reviewing progress difficult to assess and can lead to drift.
- 1.15 Attendances of children and young people at ED are shared with the school nurse. We saw evidence of school nurses reviewing these notifications and offering support to families or directly to young people as appropriate.
- 1.16 Attendances of children and young people at the Bracknell Urgent Care Centre (UCC) are not routinely reviewed to identify and respond to emerging or existing safeguarding concerns. Although we were told that practitioners would telephone through any concerns about a child to the health visitor or school nurse, we found no evidence that this happened in any of the cases reviewed. This hinders the identification of children and young people who would benefit from some level of help from these services. It also hampers the ability of health visitors and school nurses to maintain oversight of the children and young people already engaged with their services. (**Recommendation 6.1**)
- 1.17 Those children and young people up to the age of 19 who are still in education and who access the school nursing service are well supported. We saw evidence of positive impact on the lives of children and young people who had benefitted from input by the school nursing service. However, young people are unable to access the school nursing service without first asking a professional within their school or education provision to make a referral. Furthermore, a recent decision has been made to withdraw the school nursing 'drop in' service at secondary schools across Wokingham and replace this with timed appointments. These two factors combined impede open access to those young people who are reluctant to share their concerns with other professionals and there is potential for the most vulnerable children to be missed. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**

- 1.18 Drop in clinics continue to be held in targeted primary schools once every half term, which provides open access to families who seek additional advice about the physical and emotional health needs of their children.
- 1.19 Children and young people who are home educated or not in education do not benefit from the input of the school nursing service. However, although not commissioned to support this vulnerable group of children, the school nursing service do provide some support to those children who are not accessing formal education and who have a child protection plan in place. Children and young people who are not in education feature regularly in serious case reviews and this is a missed opportunity for statutory agencies to work with families to identify and respond to any emerging health concerns. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**
- 1.20 All referrals into the child and adolescent mental health service (CAMHS) are made via a common point of entry (CPE) where an initial screening takes place to direct children and young people to the most appropriate service to meet their needs. This helps avoid, where possible, unnecessary delay in children and young people receiving timely support.
- 1.21 The Wokingham 'early help hub' brings a range of services together to identify and coordinate support needs for children, young people and families. The practitioners provide support using children and young people's improving access to psychological therapies (CYP IAPT) principles of early intervention to help prevent escalation to tier three services.
- Although the service has only been in place for 18 months, reported benefits include; a timely response with the provision of an interim solution rather than prolonged waiting for CAMHS support; help for children and parents to feel empowered by ultimately managing issues themselves; tailoring support to the right place at the right time.
- 1.22 Psychological perceptions in education and primary care (PPEP) is a new training programme provided by CAMHS and aimed at staff in schools and primary care. It helps staff recognise and better understand mental health needs so they are able to provide appropriate support and guidance to children and young people. The plan is for PPEP to become a dedicated resource in Wokingham and across Berkshire, to support young people with low mood, anxiety, self-harming behaviours, specific phobias and eating disorders for example.
- 1.23 While it is recognised that waiting time targets have not yet been achieved in CAMHS, there have been several quality improvements and pilot schemes introduced to improve the CAMHS offer. However, work to reduce waiting times must be continually monitored and reviewed to ensure drift from projected timescales does not happen. **(Recommendation 5.1)**

- 1.24 Young people in Wokingham have access to a fully integrated contraception, sexual health (iCASH) and genitourinary medicine (GUM) service in a range of venues and locations. However, iCASH practitioners informed us that Wokingham schools have declined to have any iCASH sexual health service provision within school premises. This means that the opportunity for young people have access to sexual health advice and support in locations or venues that are easily accessible to them is reduced.
- 1.25 There is however, a good iCASH outreach service for young people in Wokingham and practitioners are flexible in their approach when offering appointments to vulnerable young people.

The iCASH vulnerable women's outreach nurse works closely with women who may have children in care or subject to a child protection plan, have been victims of domestic abuse or who suffer from alcohol or substance misuse. The outreach nurse also works with women from Gypsy, Roma and Traveller communities. In addition, a gap was identified locally for vulnerable boys and men and as a result a male outreach worker was recruited into post. This is a positive development and shows that iCASH services are being proactive and responding to emerging local needs.

- 1.26 A robust safeguarding risk assessment is used by iCASH practitioners for all young people under the age of 16 who access the service. The risk assessment is currently only used for 17-18 year olds if they are identified as vulnerable or they are seen by the youth outreach nurse. The iCASH service has recognised this as a gap and we heard of imminent plans to ensure that all young people under the age of 19 have a safeguarding risk assessment completed. This is important as young people aged 17-18 are vulnerable and practitioners should be supported in comprehensively and routinely identifying their needs.
- 1.27 In iCASH young people on a child protection or child in need plan are flagged on electronic health records. However, young people at risk of child sexual exploitation (CSE) are not currently being flagged. This has been recognised as a gap by the service, and there are ongoing discussions within the team on how best to upload this information on the electronic health record to help inform practice and better safeguard vulnerable young people.
- 1.28 The quality of record keeping by iCASH practitioners is generally good. In most records reviewed the voice of the young person was reflected. This is important as young people want to be listened to and involved in their care. It also helps ensure that health outcome plans are successful. However, not all plans we saw were SMART. This is important for reviewing progress and informing ongoing practice.
- 1.29 We were informed of, and saw that iCASH practitioners have good working relationship with local GPs and the midwifery service. Effective joint working between local services helps ensure young people are well supported by all the health professionals they engage with.

- 1.30 GPs at one practice we visited have access to a contraception template on their electronic health record system, and we were informed that GPs apply the Fraser guidelines as part of their assessment; however, we were unable to review any cases at the time of our review. GPs are in an ideal position to notice early signs of child sexual exploitation when children and young people present in their surgeries, if they are alert to possible indicators. Therefore, the contraception template could be strengthened to include questioning around vulnerabilities, for example number of sexual partners, domestic violence, mental health. This would better support GPs to consider and recognise those children and young people who are at risk of child sexual exploitation. (**Recommendation 4.1**)
- 1.31 One GP we spoke to reported that the names of adults who accompany children and young people to their appointment are routinely documented within the clinical assessment record. However, in cases sampled the full name and relationship was not recorded. This is important not only to ascertain who has parental responsibility for a child or young person and therefore able to consent to treatment, but in a fractured family with complex dynamics, the recording of names is as relevant as the reported relationship and avoids assumption.

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## 2. Children in need

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- 2.1 The Royal Berkshire NHS Foundation Trust has strengthened its transition planning arrangements for young people with complex health needs and this is contributing to a more transparent and co-ordinated approach in supporting young people with long term or complex needs into adulthood. A pilot aligned to the nationally recognised transition programmes 'Ready Steady Go' and 'Hello to Adult Services' is helping address long standing system challenges within health in ensuring an effectively co-ordinated and holistic approach to transition.
- 2.2 Good relationships are being forged between ED, paediatric ward staff and CAMHS to secure additional mental health care for young people who require this. This occurs on admission, during their stay on the paediatric ward, and to support their safe discharge. We saw good use of mental health triage tools and observation charts to strengthen analysis of mental health risks.

When a young person needs onward admission to a tier four mental health facility, Berkshire Healthcare NHS Foundation Trust provides regular support to the acute trust until a tier four bed is secured. When necessary, additional registered mental health nurses are funded to provide specialist support to young people whilst they are on the paediatric ward. There are effective escalation processes in place to ensure that a young person's discharge to a more suitable provision is not delayed.

2.3 The CAMHS offer to young patients who attend the ED in mental health crisis is currently 8am to 8pm Monday to Friday. Outside of these hours an on-call consultant psychiatrist is available for consultation by telephone. Young people aged 16 years and over are seen by the hospital's psychological medicine service. Those aged under 16 years are seen by the on-call junior doctor who has access to the CAMHS duty psychiatrist.

2.4 Progress is being made to strengthen CAMHS capacity to support staff in the ED in managing the care of children and young people who present with self-harm. However, the provision of care for young people aged 16 to 18 years who self-harm is inadequate and young people are not receiving appropriate support whilst they wait on adult medical wards for admission to tier four provision.

We saw one example of a 17 year old who had self-harmed and was initially placed on the adult short stay assessment unit before being moved to an adult ward while waiting for a tier four bed. The young person was not discharged to a tier four placement until 14 days after presenting at ED. Records state this case was escalated through the correct channels, the trust highlighting that this young person was inappropriately sharing a bay with elderly patients. An acute hospital adult ward is not an acceptable age appropriate setting and contrary to national service standards.

Gaps in this area and the requirement for a 'whole system' approach are acknowledged by senior managers of both trusts. (**Recommendation 2.2**)

2.5 Children and young people accessing the UCC do not always benefit from a thorough assessment of their safeguarding needs. We saw evidence of need being identified and families being referred to children's social care. However, there is no consistent approach to carrying out a safeguarding triage and we noted an over-reliance on professionals asking about and documenting the areas of risk that NICE guidance recommends are explored by emergency practitioners. (**Recommendation 6.2**)

2.6 A specialist health visiting team provides support to all families from a Gypsy, Roma and Travelling community in Wokingham enabling access to early help and timely support. There are currently no other specialist health visitor roles; however, we were informed of a number of health visitor champions with specialist interests in areas such as domestic abuse and children with complex needs.

2.7 Procedures for families and children under the age of five moving into the Wokingham area and transferring into the health visiting service are well embedded; however there appears to be some variability in practice for families transferring out of area.

In one case we looked at, a family with a child on a child in need plan moved to a neighbouring area within Berkshire. There was no formal handover of care, no transfer summary on the health record and no evidence seen of any liaison with the new health visitor. This was a failure in prompt sharing of essential information to ensure the new health visitor was aware of key issues, plans and any ongoing work to help meet the needs of the family and child. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**

2.8 In most health visiting records we saw evidence of questions relating to maternal mental health being routinely asked and recorded. We were informed that if enquiries about domestic abuse could not be made by the health visitor this would be documented within the assessment paperwork; however we found that this was variable. It is important that health visitors routinely ask key questions to help identify early support that may be required by a family as well as to help them assess the potential impact of any domestic abuse or maternal mental ill-health within a household. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**

2.9 All GPs in Wokingham have a health visitor attached to their practice; however, we were informed that health visitors do not all routinely attend GP practice vulnerable families or safeguarding meetings. The absence of regular and formal meetings between professionals is a missed opportunity to ensure a co-ordinated approach in supporting vulnerable families. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service. (Recommendation 1.1)**

A new mother had a long history of depression and anxiety which she did not disclose during the ante natal or immediate post-natal period. However, the health visitor became aware of emerging maternal low mood, increased anxiety and patterns of OCD. Additional support visits were scheduled and the health visitor worked closely with the mother to encourage her to meet with her at the local children's centre instead of the home environment. The health visitor referred the mother to the children's centre's family support worker and mum is now taking the baby to groups and is accessing counselling services until the talking therapies service are able to offer an appointment.

2.10 In CAMHS the risk assessments we saw were of good quality and were routinely and regularly updated. Records of the care planning process are of variable quality. For example, plans we looked at were not always SMART, which would help to review progress, inform ongoing work and avoid drift.



- 2.11 Waiting time targets for CAMHS tier three support are for 95% of young people, apart from those on the ASD pathway, accessing services within six weeks and 95% of young people on the ASD pathway accessing services within 12 weeks. These targets are recognised by partners to be challenging and are not yet being routinely met. The Trust is actively working towards improving waiting times, aiming to achieve a maximum wait of 12 weeks by July 2016 and the six week target by October 2016 for all teams except the ASD diagnostic service where the aim is for the 12 week target to be achieved by October 2017.
- 2.12 There is no transition policy in place between young people's substance misuse services and adult services. Although we were informed that there have not been any such cases identified, it is acknowledged by the provider that some young people could potentially be discharged by the youth service when they might have benefitted by a managed transition into the adult service. **This issue has been drawn to the attention of Public Health, as the commissioners of the substance misuse service.**
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### 3. Child protection

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- 3.1 At Royal Berkshire NHS Foundation Trust ED and maternity services, the named nurse and named midwife for safeguarding have good oversight of safeguarding cases. Robust systems are in place for making and tracking the outcomes of referrals to children's social care (CSC) or other community health partners.
- 3.2 We saw that ED staff are vigilant to risks of harm to children and their electronic flagging system provides appropriate alerts about children and vulnerable adults. There are clear pathways in place for the admission and management of children aged under 16 at risk of harm, including self-harm, which are compliant with NICE guidance.
- 3.3 We saw positive joint working with Wokingham Children's Social Care 'Brambles' team; with good feedback by CSC regarding the outcomes of referrals made and any subsequent assessment activity. This ensured the trust was able to keep its records up to date about concerns they had raised.
- 3.4 ED staff are alert to risks of CSE and ensure appropriate follow up checks are made to assess risk and keep a young person safe. We saw good sharing of intelligence with partner agencies. ED staff are vigilant where parents attending have substance misuse or mental ill-health and risks to children are appropriately shared with CSC.

A young female was admitted to the paediatric ED after allegedly drinking a whole bottle of vodka.

Staff were concerned that she was at risk of CSE so involved the police and children's social care.

A full child protection medical, pregnancy and toxicology tests were undertaken.

The young person had no record of any previous ED attendances and she was not known to CSC.

The outcome was that it was considered safe to discharge her home.

Recording by ED staff was comprehensive in terms of the young person's presentation and explanation of the incident. The young person's voice was evident.

- 3.5 The electronic patient record system used in the UCC does not highlight any children or young people who are on child protection plans or who are looked after by the local authority. Practitioners are reliant on parents or carers disclosing their involvement with CSC. In all records we reviewed families had been asked if a social worker was working with them. Where this was affirmed then details of the attendance were shared with CSC. The overreliance on self-disclosure of CSC involvement may lead to essential information not being shared to inform on going risk assessments where there are identified safeguarding concerns within a family.  
**(Recommendation 6.3)**
- 3.6 Opportunities to identify vulnerable children of parents who present to the UCC with domestic abuse, drug or alcohol misuse or other concerning behaviours are being missed. The electronic patient record does not contain any prompts to ensure practitioners explore and record the details of any children the presenting adult may have caring responsibilities for, and we saw variable practice in relation to this. This means that the impact of an adult's behaviour on their parenting capacity and the consequential effect on the health and wellbeing of a child is not being fully considered. Therefore steps to ensure the safety or wellbeing of children are not always being taken.  
**(Recommendation 6.4)**
- 3.7 We saw examples of vulnerable children and young people being identified by staff at the UCC and that appropriate referrals are being made to CSC. We saw that arrangements are in place to ensure that children and young people who attend the UCC are, where necessary, transferred to the local ED for further safeguarding assessment.

- 3.8 At the Royal Berkshire NHS Foundation Trust an adapted and shortened multi-agency referral form (MARF) is used to refer cases to children's social care. The referrals we saw from midwifery services were variable in quality. Overall, they were narrative in nature and although they shared basic information there was limited analysis or articulation of risk. The potential impact of parenting behaviour on a new born was not clear, the expected outcome of the referral was not included and they did not relate or refer to the local threshold document. **(Recommendation 3.4)**
- 3.9 Midwives are invited to and are expected to attend and provide reports for pre-birth safeguarding meetings. However in the notes we sampled, referrals to CSC, invites to meetings, including initial child protection conferences (ICPC), reports for conference and minutes from safeguarding meetings were not routinely included in maternal records and there was a noticeable gap in the information held. We were unable to follow or identify the midwifery input into safeguarding or child protection multi-agency decision making. This lack of information in notes prevents midwives from being fully informed of current child protection risks and concerns for the unborn or new born in their care. **(Recommendation 3.5)**
- 3.10 At Royal Berkshire NHS Foundation Trust the named midwife ensures safeguarding or social issues are appropriately flagged on the electronic patient records system. In paper records, clearly identifiable blue child protection communication sheets were consistently used to alert the wider maternity team of cases that had reached safeguarding thresholds.
- 3.11 Pre-discharge planning arrangements and documentation was robust in the maternity department; however in the cases we reviewed the electronic discharge summary did not contain any safeguarding information, even when a new born was subject to a CiN or CP plan or a written agreement was in place for example. This is a missed opportunity to ensure community colleagues, including GPs, are fully aware of all current safeguarding issues and that as lone workers their safety is also considered. **(Recommendation 3.6)**
- 3.12 Health visitors in Wokingham flag vulnerable children and families including children subject to a child protection or child in need plan on the electronic patient record system. This ensures health visitors are immediately aware of families and children where additional support may be required and facilitates appropriate liaison with other professionals involved with the family.
- 3.13 Liaison between the health visiting and midwifery services is reported to be variable across Wokingham. We were informed that where discussions do take place the outcome of the discussion is logged in the electronic patient records system; however, we saw no evidence of this in cases we reviewed. It is important that health visitors and midwives meet regularly, as any vulnerability or risk can be identified prior to scheduling antenatal contacts. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service. (Recommendation 2.1)**

- 3.14 Health visitors in Wokingham are invited to and are expected to attend all child protection and child in need meetings. However, we saw evidence that not all health visitors are being invited to attend pre-birth ICPC's. This is a missed opportunity to ensure health visitors are involved with vulnerable families at an early stage. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**
- 3.15 In records reviewed we saw evidence of reports being produced for child protection meetings. These clearly articulated health visitors' concerns, as well as what was working well for the family. However, we were told that conference reports are not currently being quality assured by managers and this may result in variability in the quality of information being shared at meetings. We were informed that all conference reports are reviewed by the Safeguarding Children's Team and quality issues are discussed with individual practitioners.
- 3.16 There is an expectation that school nurses are invited to strategy meetings or child protection conferences where a school age child is being discussed. This should ensure that any known health needs or concerns are taken into consideration. However, we did see examples where this had not happened. We also saw instances where opportunities for a school nurse to become involved with and support vulnerable children, especially those who were also accessing other therapies, were being missed. School nurses have a vital and unique role in supporting the emotional and physical health of children and young people and it is important that this is recognised by professionals working across the partnership. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**
- 3.17 Referrals to children's social care from school nurses are made using the local MARF. Those school nursing referrals we saw during the review were good and reflected the changes within Wokingham Children's Social Care to move to a more strengths and risk based approach. However, these are not always uploaded onto the electronic patient records system which means that sometimes records are incomplete. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**
- 3.18 School nurses are expected to provide a report for child protection conferences and share this with the trust's named nurse. Those reports seen were good and had been shared with families prior to the conference taking place. This helps to engage families in the process.

- 3.19 Recording by school nurses clearly articulates the voice of the child. Reports and health assessments clearly analyse risk. However, the health contribution in child protection, child in need and team around the family (TAF) plans are not always underpinned by SMART planning from the health visitor or school nursing service. Plans we saw were often task orientated without clear outcomes or timeframes. This is a missed opportunity to bring clarity to the purpose of any health intervention for both the practitioner and the family.
- 3.20 CAMHS practitioners are encouraged and supported to attend all initial child protection conferences and to provide reports to inform those meetings. Attendance at review conferences is not obligatory unless there has been specific, recent CAMHS input that might inform the decision making process, however staff are required to send reports.
- 3.21 Although we saw that CAMHS practitioners are recording their attendance at child protection meetings, the uploading into client records of resultant information and planning is variable, resulting in some records being incomplete. (**Recommendation 7.1**)
- 3.22 Records we looked at showed that CAMHS practitioners are reluctant to make any assertions or share opinions about risks when sending reports for child protection meetings or in referrals to children's social care. For example, in one child protection conference report the practitioner stated they were unable to make a decision until they had heard the views of other professionals. This does not support good decision making as it does not fully inform the conference of risks in the context of a client's mental health. (**Recommendation 7.2**)
- 3.23 CAMHS practitioners make use of the comprehensive CSE toolkit when potential risk is recognised. However, in one case examined we saw that although a young person was identified as being at high risk of CSE, practitioners did not record any required actions to reduce the risk. There is an over-reliance on other professionals taking responsibility for identifying and implementing risk avoidance strategies. (**Recommendation 7.3**)
- 3.24 Adult mental health practitioners undertake a comprehensive assessment of clients when they are referred into the service. This includes identifying children and young people whom the client has access to, or for whom they have parental or carer responsibility.

Where a client discloses that they are in a new relationship, a further assessment is undertaken, which includes identifying any new young people they might have access to.

The adult mental health service automatically notifies health visitors and school nurses when they begin work with clients who have children or access to young people.

However, care plans in the adult mental health service do not include actions that should be taken when adult patients whose behaviour indicates a heightened risk have access to vulnerable children and young people, especially those subject to child protection measures. The care plans are therefore not considered complete. (**Recommendation 7.4**)

- 3.25 In adult mental health services the use of the alert system on the electronic patient record system is under developed. Practitioners are not 'flagging' concerns, such as when there are known child protection risks to children and young people in the care of adult clients. There is an over reliance on other health services, such as health visitors, raising alerts on client records to inform practitioners of any safeguarding issues. (**Recommendation 7.5**)
- 3.26 Adult mental health practitioners, particularly the perinatal mental health team, are routinely invited to attend pre-birth planning meetings and practitioners will undertake joint visits to the client's home so that a full assessment can be made of the home environment and potential risk.
- 3.27 Attendance at initial and review child protection conferences are prioritised by perinatal mental health practitioners. The reports for conference we saw were comprehensive and contained an appropriate amount of detail regarding parenting capabilities and risk.
- 3.28 'Think Child' is well established in adult substance misuse services. When a client is referred into the service they are subject to a robust initial assessment which includes gathering details of all children and young people with whom they have either parental or carer responsibilities. It also includes questions about other young people that they might have access to including family and friends. If there are any concerns regarding young people's safety or if it is disclosed that children are subject to child protection measures then the practitioner will make contact with children's social care to advise of the contact and confirm details.

Parental capacity is assessed and re-assessed at subsequent meetings, which is good practice to ensure risks to vulnerable children and young people are continually assessed.

- 3.29 Adult substance misuse practitioners are routinely invited to attend all initial and usually review child protection conferences. Reports are provided and minutes from the meetings obtained. We saw that the reports to conference were of a good standard. All records examined contained the outcomes from meetings and practitioners are positively encouraged to maintain a prominent role in the child protection process.

- 3.30 Despite positive recognition of risk to young people by adult substance misuse practitioners, in records examined we saw that recovery plans pertaining to that risk were not SMART. There were no clearly defined time scales or responsibilities allocated in relation to actions to protect young people in those plans although it is recognised that other information in client records, such as minutes of child protection meetings is available to make practitioners aware of risk.
- 3.31 Recovery plans are shared with partners when requested, such as by health visitors. Relationships with other multi-disciplinary partners such as school nurses and GPs are variable. For example, recovery plans have been offered to school nursing services where young people are living with adults who abuse substances, but the take up of the offer has been poor. This is a missed opportunity for school nurses to be better informed of risks to children in their care. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**
- 3.32 It is recognised by substance misuse managers that more work needs to be done with GPs to improve the safety of adult clients, particularly around medication and prescriptions, to prevent any negative impact on the safety of children or young people in their clients care. Adult substance misuse practitioners routinely notify GPs of their work with clients but there are no shared care arrangements between services. **This issue has been drawn to the attention of Public Health, as the commissioners of the substance misuse service. (Recommendation 4.2).**
- 3.33 Adult substance misuse practitioners do not undertake any assessment of client home environments due to the limited number of practitioners currently working in the area. Home visits are an opportunity to protect potentially vulnerable children and young people by reviewing the safe management of prescribed medication and for practitioners to assure themselves that the home environment is safe. **This issue has been drawn to the attention of Public Health, as the commissioners of the substance misuse service.**
- 3.34 iCASH staff use the amended Royal Berkshire NHS Foundation Trust form to refer cases to children's social care. The referrals reviewed were narrative in format and used predominantly as information sharing tools. Although the information was relevant, risks to young people were not clearly articulated or analysed, referrals were not outcome focused and did not relate to the local threshold document. **This issue has been drawn to the attention of Public Health, as the commissioners of the sexual health service.**

- 3.35 We were informed that the iCASH youth outreach worker is not routinely invited to attend and contribute to child protection and child in need meetings. iCASH practitioners hold key information which can contribute to the health and wellbeing of young people and where applicable should be fully involved in safeguarding processes. **This issue has been drawn to the attention of Public Health, as the commissioners of the sexual health service.**
- 3.36 At one GP practice visited vulnerable children, young people and adults have their records coded and flagged on the GP's electronic patient records system. We saw evidence of flags to indicate female genital mutilation (FGM), CP and looked after children (LAC) as well as domestic abuse. However, one GP told us that whilst victims and children in households of domestic abuse were flagged, there was a lack of guidance on if and how to identify perpetrators on the system and they felt that there was a tension between coding the record and a patient's right to access their medical record. (**Recommendation 4.3**)
- 3.37 We saw evidence that child protection reports, conference minutes and child protection plans are uploaded onto the patient's file which gives GPs full information to inform their consultations with a child or young person protected by a plan.
- 3.38 GPs informed us that they are fully aware of the process to follow when making a referral to children's social care. However, we were unable to assess the quality of such referrals in one GP practice as we could not retrieve any records of referrals due to there currently being no management oversight of the number of referrals made.
- 3.39 The Royal Berkshire NHS Foundation Trust is represented at Wokingham's multi-agency risk assessment conference (MARAC) and domestic abuse repeat incident meetings (DARIM). This ensures appropriate information is shared between multi-agency partners and is good practice.

Adult mental health services are also represented at the MARAC and any issues pertaining to domestic abuse are then shared with the appropriate case practitioner and records updated accordingly. Outcomes are also discussed at monthly team meetings so that all staff are aware of current risks to families of clients.

An adult substance misuse practitioner plays an active part in the area's monthly MARAC meetings. Information regarding domestic abuse is then shared with colleagues. This is particularly useful for practitioners working with a client subject to the MARAC process whose children might witness violence in the family.



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## 4. Looked after children

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- 4.1 The Designated Doctor for looked after children at RBHFT, and a community paediatrician are responsible for conducting initial health assessments (IHAs) and the resultant health care plans. These new arrangements for administering IHAs provide a more cohesive approach than was historically in place. Work is ongoing to streamline the IHA process with adoption medicals to provide a seamless and timely response to permanence plans for children.
- 4.2 IHAs and review health assessments (RHAs) are undertaken for all looked after children placed in the Wokingham area and within a 20 mile circumference for those placed out of Berkshire. The most recent IHAs and health care plans seen for children placed within area were of a good standard. In two cases where young people were placed out of this radial area we identified that their IHA was not completed in a timely manner; both were significantly overdue. Once highlighted, the designated nurse for LAC ensured these were resolved whilst we were on site.

We also saw an IHA completed by a GP for a young unaccompanied asylum seeking child placed out of area. This provided only a basic picture of his health needs with limited focus on his identity, self-esteem and minimal information about his emotional and mental wellbeing despite it being documented that he was feeling unhappy and found it difficult to explain his low mood, even with a translator. This means that it was not clear if his mental and emotional wellbeing had been appropriately considered as part of his health plan.

Whilst positive efforts have been made to ensure the timely delivery of IHAs and RHAs, further work is required to address quality and to strengthen focus on young people placed out of area. (**Recommendation 1.2**)

We saw one IHA which clearly outlined parental health risks and the potential impact on the child's life, including attachment difficulties, mental health and substance misuse issues.

Comprehensive screening and developmental checks were undertaken with a good focus on health promotion. We noted child centred observations of the child's demeanour and interaction with the paediatrician.

The assessment was very child centred with a clear and succinct analysis of the child's health needs.

A detailed health care plan was in place and accountabilities were clearly documented regarding areas for action to promote the child's health and development.

There was evidence of good engagement and feedback from the GP and health visitor in providing an up to date picture of health history and known social circumstances of the child

This was a clear and succinct assessment of the health and development needs of this young child and appropriate actions around how to best meet the identified needs were documented.

- 4.3 RHAs are completed by a range of practitioners. Generally health visitors conduct RHAs for looked after children aged up to five and school nurses for school age children. However community nurses and a specialist LAC nurse will also conduct reviews as appropriate.
- 4.4 We were informed that health visitors are tasked to complete the assessment and summary section on the health form whilst the health plans are completed by the looked after children's nurse. Recent RHAs we looked at that had been carried out by health visitors provided a clear focus on children's identity, development, attachment and social interaction.
- 4.5 School nurses have recently received update training on the health needs of LAC and the LAC health review process. Most children and young people choose to have their health review within their home environment, although they are always given a choice. School nurses try to ensure the same nurse carries out the annual review to give some continuity to the child or young person. The RHAs completed by school nurses that we saw were of a satisfactory standard with good recognition of risks and positive health promotion.
- 4.6 Where health assessments and health plans were carried out by the LAC specialist nurse we saw work that was generally comprehensive and young person centred. For example, in one case we saw good liaison and support from the LAC specialist nurse in ensuring a young person at high risk of CSE received the help they needed from CASH and CAMHS.

- 4.7 A strengths and difficulties questionnaire (SDQ) is used to assess the emotional and behavioural health and wellbeing of looked after children. In Wokingham the 2015 average SDQ score was 17.1 which is significantly above the England average of 13.9. The average score has increased since 2013, which suggests that the emotional health and wellbeing of looked after children in Wokingham may be deteriorating.

Strength and difficulty questionnaire scores were not seen in any case records during our review, indicating poor attention to the emotional and mental wellbeing of looked after children. This remains an area for continued improvement. (**Recommendation 1.3**)

- 4.8 The use of a 'Drug Use Screening Tool' (DUST) is not embedded in practice and in the health reviews we looked at some cases where parental substance misuse was an issue needed further exploration in relation to the child's views and experiences. Current arrangements do not focus strongly enough on early intervention and prevention of substance misuse. (**Recommendation 1.4**)

- 4.9 Children looked after are not benefitting from routine input from their GP into the initial health assessment or health reviews. This means that health plans may not be informed by all pertinent, up to date health information.

- 4.10 LAC nurses are routinely advised of children attending ED and their vulnerability status is appropriately flagged on the trust systems.

However, the attendance at the UCC of children and young people who are looked after are not routinely shared with the LAC health team. It is important for the LAC health team to receive relevant UCC attendance information to ensure that they have a complete oversight of the health of the children they work with. (**See recommendation 6.3**)

- 4.11 The iCASH youth outreach nurse works with relevant young people as identified by the LAC team at the time of assessment and referred for outreach support. One-to-one appointments are offered, which means that the most vulnerable young people are able to access sexual health services.

- 4.12 Leaving care passports are routinely supplied which provide young people with relevant information in relation to their health history and considerations in relation to the future management of their care. Good input of the Children in Care Council into the design of the passports and the development of an 'app' has been beneficial. Berkshire Healthcare Foundation Trust has a 'Bright Ideas Group' which encourages innovations such as the use of health promotion technology with young people.

- 4.13 A primary CAMHS practitioner is allocated half a day each week to provide advice, training and guidance to children's social workers in the 'Here 4 U' children and young people's team. This team provides support to looked after young people aged up to 21 years in Wokingham. The CAMHS practitioner helps social workers review the way that they work with young people who might otherwise be difficult to engage with.

A children's social worker contacted the CAMHS practitioner in the Here 4 U social services children and young people's team to ask for advice regarding a young person they were working with. The young person was refusing to engage with CAMHS due to ongoing social isolation issues and there was risk of placement breakdown as the young person was not engaging well with their foster carers.

The CAMHS practitioner had several meetings with the social worker and made suggestions on how best to engage with the young person.

The social worker was able to confidently focus on developing a relationship with the young person and the process is ongoing, but the social worker reports that the young person is engaging better with their foster carers, interacting well with the social worker who is now also engaging with the young person's school to better understand the environment there.

- 4.14 There is no specific CAMHS offer to looked after children in Wokingham. However CAMHS assessments of children looked after are given priority and are offered routinely within two weeks unless considered urgent in which case the assessment will take place within 24 hours.
- 4.15 Berkshire CAMHS provide care and support services to children and young people looked after who are placed into the area from other local authorities. Likewise, where Wokingham's looked after children are placed out of area CAMHS liaise appropriately with other areas to ensure the correct care and support package is provided to those young people.

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# Management

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

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## 5.1 Leadership and management

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- 5.1.1 Resourcing and contractual arrangements for the designated nurse for looked after children are inconsistent with the intercollegiate guidance. There is no service level agreement between the host NHS provider, Berkshire Healthcare NHS Foundation Trust, who employs the designated nurse and the CCG where the statutory responsibility for the post is held.

The long term vacant role of designated nurse for LAC in West Berkshire (which Wokingham is part of) is being covered by the designated nurse for East Berkshire. The designated post holder is supported by a part time specialist nurse for LAC. However, it is unsustainable for one designated nurse for LAC to work effectively across two areas. The designated nurse for LACs focus has, out of necessity, been improving children and young people's access to timely review health assessments, but this has resulted in a lack of development in services for over 12 months. This is compounded by the fact that there are no named nurses for LAC in East or West Berkshire and means that the designated nurse and named nurse capacity for the LAC service is insufficient to enable effective service development and delivery.

We were told that the NHS provider trust is currently reconfiguring the service, however, we are unsure as to why there has been such extensive and unacceptable delay in resolving these long standing issues by the CCG. **(Recommendation 5.2)**

- 5.1.2 The arrangements for safeguarding children operate within a complex landscape of six local authorities and seven CCGs. Reading CCG host the safeguarding team for West Berkshire which consists of three CCGs. Executive responsibility for safeguarding is held by the CCG chief nurse. The assistant director of nursing has, as part of her role, the designated nurse function and is accountable to the chief nurse. The designated nurse manages a small team of named nurses for adults and children. The designated nurse is due for retirement and interim arrangements are in place whilst the CCGs recruit to the post.

- 5.1.3 The designated doctor for child protection is working across all six local authority and seven CCG areas. The CCGs acknowledge that this is unsustainable. There are plans to build in capacity and confidence across Berkshire to enable local paediatricians to once again support the designated doctor function. The current designated doctor has indicated that this will take place no later than April 2017, however, this is some considerable time away and the current arrangements are fragile.  
**(Recommendation 5.4)**
- 5.1.4 Wokingham benefits from the support of a named GP who works closely with the CCGs named professional for safeguarding children to improve primary care's contribution and liaison across the partnership. A current priority is the quality and timeliness of reports to child protection conferences. We also heard about regular meetings between the primary care safeguarding leads and the CCG to promote best practice and discuss and disseminate local and national learning.
- 5.1.5 At Royal Berkshire NHS Foundation Trust ED the leadership and management of safeguarding activities is strong with clear governance and accountabilities, and there is good engagement by trust senior managers and safeguarding staff in the work of the LSCB.
- 5.1.6 In the maternity department the named midwife leads on developing and promoting good safeguarding practice. Since taking up post there have been acknowledged improvements in midwives' safeguarding awareness, knowledge and practice. She has developed good working relationships with multi-agency professionals leading to better information sharing and joint working to improve outcomes for vulnerable women.
- 5.1.7 In the maternity department there is a clear governance structure and regular meetings ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board.
- 5.1.8 All health visitors attend one-to-one management meetings, every six weeks during which caseloads are reviewed. This is a good way for managers to maintain oversight of workload commitments.
- 5.1.9 In school nursing the trust's executive lead for safeguarding is supported in this role by the lead for safeguarding. The safeguarding team who are made up of a number of named professionals provide supervision, training and ad-hoc support to staff working for the trust.
- 5.1.10 Transition to adult services from CAMHS starts officially at age 17 and a half although where the likelihood of transition is recognised at an earlier stage then this can start at age 16 upwards. Learning from difficult to manage transition cases pertaining to young people living with eating disorders has positively influenced and improved overall CAMHS transition processes.

- 5.1.11 The deputy manager in adult substance misuse services actively audits and maintains oversight of practitioner case files, especially where safeguarding concerns exist. We saw that where it is known that children and young people are subject to child protection measures then a duplicate paper record will be maintained alongside the electronic record to ensure practitioners always have access to important safeguarding information.
- 5.1.12 There is a safeguarding lead GP meeting every quarter and GPs attend when possible. Attendance of safeguarding lead GPs at these meetings is important as it encourages discussion and liaison with peers. It is also a good opportunity for information sharing and raising awareness of changing practice, which can then be cascaded to GP colleagues and other practice staff. Minutes of these meetings are sent to all safeguarding lead GPs, ensuring that those who are unable to attend receive timely information.
- 5.1.13 We were informed that the named professional for safeguarding children in Wokingham also sends quarterly newsletters to all safeguarding lead GPs. In the past this has included topics such as CSE risk assessment tools and updates on polices etc. which ensures GPs are kept up to date with current national and local safeguarding issues.
- 5.1.14 The nurse consultant at iCASH is proactive in ensuring on-going improvements to the service offer for vulnerable clients, and demonstrated strong and inspiring solution based leadership.
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## 5.2 Governance

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- 5.2.1 Effective arrangements are in place to provide assurance to the CCG that providers are compliant with evidence based and locally agreed safeguarding children practice. Clinical Quality Review meetings take place quarterly and child safeguarding is represented by the chief nurse. Recent improvements directed and monitored by the CCG include compliance with mandatory training, and improvement in the timeliness of children and young people's review health assessments. All NHS providers are expected to complete annual safeguarding self-assessments as well as audits required by Section 11 Children Act 2004. These are scrutinised by the CCG safeguarding team with action plans agreed between commissioners and providers.
- 5.2.2 A tracker has recently been introduced by the West Berkshire CCGs to monitor progress of action plans agreed as a consequence of serious case reviews and partnerships reviews. This could be strengthened by extending it to include actions arising from peer reviews or other inspection activity. This would enable the CCGs to consistently monitor and demonstrate compliance with best practice across the area.

- 5.2.3 The CCGs across the West of Berkshire hold quarterly named and designated professional meetings and there is a quarterly CCG safeguarding committee meeting which local providers attend. Records we looked at demonstrate that this is effective in ensuring consistent messages and safeguarding children activity in the area.
- 5.2.4 The RHA process has not always been robust with one professional completing the assessment, another professional capturing the key information in a health summary, and in some cases a further professional writing the health care plan. This is too disjointed with lack of a holistic focus on the child and is too open to the risk that records could be misinterpreted with this split of responsibilities. We have been informed that this process has recently changed and it is anticipated that the revised CoranBAAF health assessment forms will be implemented when they are available, which should further strengthen the process. These changes need to be monitored to ensure a child centred focus is maintained.  
**(Recommendation 5.3)**
- 5.2.5 The stand-alone electronic patient records system used in the UCC is not able to effectively share information with other local health providers. All attendances are shared with the patient's GP; however attendances are not shared with health visitors or school nurses. We saw examples where details of either an adult's or child's attendance would have been most useful to the health visitor or school nurse, especially where the threshold for intervention by children's social care was not met but the initiation of early support would have been beneficial to the child or family.  
**(Recommendation 6.1)**
- 5.2.6 Audit on safeguarding practice is underdeveloped within the UCC. The safeguarding lead for OneMedicalGroup is unable to obtain assurance on the quality of identification and protection offered to children and young people. **(Recommendation 6.5)**
- 5.2.7 In the school nursing service the recent addition of a 'safeguarding page' and the open access to the trust's electronic patient records system is proving to be of significant benefit. We could see how the safeguarding page is providing practitioners with quick access to key safeguarding information and makes navigating between pages of the patient's record significantly easier.
- 5.2.8 In school nursing and midwifery services the inconsistency in record keeping around the availability of key documentation such as referrals to children's social care and health assessments indicates a lack of routine quality assurance. Where arrangements to routinely audit and quality assure record keeping is embedded, this promotes continuous improvement in practice. **This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.**



- 5.2.9 The CAMHS practitioner working within the 'Here 4 U' team does not currently benefit from a specific job description. Consideration should be given to recognising the importance of the role and the time taken to improve relationships between CAMHS and children's social care.  
**(Recommendation 7.6)**
- 5.2.10 Berkshire CAMHS are pro-active in the use of information technology to provide information and alternative support strategies. This includes the implementation of social media and peer support provided in online chat rooms which will be monitored by trained service users and CAMHS staff. This is a familiar and good self-help resource for young people to use whilst waiting for further CAMHS interventions.
- 5.2.11 The Berkshire Healthcare NHS Foundation Trust's community mental health and CSC joint working protocol aims to ensure that their staff work in partnership to safeguard and promote the welfare of children and families where parents or carers have mental health issues and CP or CiN concerns are identified. It highlights the importance of recognising that parental mental health should be viewed as a significant risk factor directly affecting a parent's or carer's ability to provide consistent parenting and protect children in their care.
- 5.2.12 Wokingham adult mental health services are a mix of health practitioners and those employed by the borough council. Practitioners and managers feel this is positive as each can share skills and knowledge to better 'think family' and safeguard vulnerable people with whom they have contact. We were advised of a diversity of skills and interests amongst practitioners which has informed service provision including the now, well established, perinatal mental health service.
- 5.2.13 Adult mental health managers are aware that more work needs to be undertaken to educate GPs and other health professionals on referring cases to the most appropriate part of the mental health service according to need. We were informed that minor causes of concern are routinely referred at the highest level which is not an appropriate use of resources and might not best serve the client or any children or young people the client has access to, or for whom they have parental or carer responsibility.
- 5.2.14 A healthcare record keeping audit was undertaken in the iCASH service in August 2015. This demonstrated that practitioners are compliant with completing the safeguarding risk assessment for all young people under the age of 16 accessing the service. A review audit is scheduled for June 2016.

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## 5.3 Training and supervision

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- 5.3.1 The CCG designated and named nurses provide one to one supervision to provider named safeguarding nurses on a bi-monthly basis.
- 5.3.2 A training sub group of the three West Berkshire LSCBs meet to agree and discuss local training. Providers attend and submit their prospectus and arrangements for scrutiny. This pan-West Berkshire approach helps to promote consistency in the experience of children, young people and families receiving support, especially as families frequently cross boundaries between the CCGs.
- 5.3.3 LAC nurses have provided additional training to health visitors and school nurses around the required standards of assessments and care plans. They have recently provided a clear picture of children and young people's needs, with particular attention being paid to their identity and contact with family.
- 5.3.4 There is a positive programme of work being piloted by the Royal Berkshire NHS Foundation Trust to build the capacity and expertise of its workforce in strengthening recognition and support for children and young people with mental health needs.
- 5.3.5 At Royal Berkshire NHS Foundation Trust ED, staff are kept up to date with practice developments in areas such as CSE, FGM and radicalisation awareness training known as 'PREVENT'. The intranet provides a good range of resources and learning materials to support their work with a strong focus on the experience of the child or young person at the centre.
- 5.3.6 In the ED, supervision and peer review arrangements are regular and well-embedded and have been effective in promoting shared learning and reflection on complex cases.
- 5.3.7 Practitioners working at the UCC are expected to attend level three safeguarding children training. Historically this had been on-line training only and this is acknowledged as not being best practice or in line with intercollegiate guidance. (**Recommendation 6.6**)
- 5.3.8 Although practitioners at the UCC access regular clinical supervision, there is no access to safeguarding supervision. (**Recommendation 6.7**)
- 5.3.9 Midwives at Royal Berkshire NHS Foundation Trust hospital access level three safeguarding children training, however they do not currently fulfil the learning hours required and therefore training is not fully compliant with the intercollegiate guidance. (**Recommendation 3.7**)

The current use of training passports within the maternity department is an effective method of capturing and evidencing the wide variety of safeguarding children learning opportunities available to and accessed by staff.

- 5.3.10 The vulnerable women's team of midwives are offered one-to-one safeguarding supervision sessions on a quarterly basis and we saw that where individual cases were discussed this was acknowledged in client's records. However, any identified actions resulting from the supervision session are currently held separately. This means that women's notes are not a full and complete record and that actions are not informing the care planning process as they are not visible to the wider maternity team.

Community midwives at Royal Berkshire NHS Foundation Trust, as caseload holders, would also benefit from in depth one-to-one supervision sessions, particularly as there are plans to place newly qualified midwives in the community setting. This would help to ensure a degree of professional challenge in cases where increased support or intervention with vulnerable women is identified and that potential risk or drift is not overlooked.

**(Recommendation 3.8)**

- 5.3.11 Health visitors in Wokingham attend mandatory level three multiagency safeguarding children training every three years, which is in line with intercollegiate guidelines. In addition, health visitors have access to a range of other training, including maternal mental health, CSE, FGM and domestic abuse, 'signs of safety' and PREVENT. It is important that practitioners are accessing specialist training relevant to their role in order to ensure that they are up to date in relation to safeguarding children and providing families with appropriate support, guidance and advice.
- 5.3.12 All health visitors have access one-to-one safeguarding supervision with the trust safeguarding team three times a year. We were informed that outcomes following safeguarding supervision are documented on the electronic patient records; however the individual child protection supervision document template completed during supervision is not routinely scanned onto the health record and does not always reflect the patient's record. In addition, outcomes following safeguarding supervision sessions were not always SMART. This is important for reviewing progress and informing ongoing practice. **This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.**
- 5.3.13 School nurses are expected to undertake level three safeguarding children training. Practitioners are encouraged to attend the multi-agency LSCB training and the named professionals also run a number of forums and seminars accredited as level three training on learning from serious case reviews and other relevant topics which are popular with staff.

School nurses have recently received additional training helping them to understand the new approach across Wokingham's CSC to a more strength's based approach. This helps practitioners to write appropriate referrals that inform the social worker in their initial assessment.

- 5.3.14 School nurses are expected to access safeguarding supervision at least every four months. All children and young people who are protected through a child protection plan must have their care discussed and school nurses are invited to bring any other case that they feel would benefit from in-depth discussion and reflection. We saw evidence on patient records on the outcome of supervision, including any tasks that had been agreed.
- 5.3.15 CAMHS practitioners in Wokingham are trained to level three in accordance with intercollegiate guidance. Training is provided in a multi-agency setting with single agency training also available in relation to learning from serious case reviews and local issues including CSE.
- 5.3.16 Safeguarding supervision is offered to CAMHS practitioners in peer support groups four times each year with an expectation that they attend three of the annual sessions. Practitioners bring cases for discussion although there is currently no provision to 'dip sample' cases to check if safeguarding issues have been missed.

In CAMHS the outcomes from safeguarding supervision is recorded appropriately in client records and informs the care planning process where appropriate.

- 5.3.17 The current young person's substance misuse practitioner is trained to level one safeguarding children. This is not in line with intercollegiate guidance as the practitioner has routine one-to-one contact with young people, sometimes in their own home and should therefore be trained to level three. **This issue has been drawn to the attention of Public Health, as the commissioners of the substance misuse service.**
- 5.3.18 Although we saw that practitioners in adult substance misuse do not receive specific safeguarding children supervision they do receive support at regular monthly meetings and can access advice and guidance as and when required. When safeguarding practice is discussed we saw that this is appropriately recorded in client's records.
- 5.3.19 Perinatal mental health practitioners provide training to multi-disciplinary and multi-agency professionals including social workers, health visitors and school nurses. The training includes; awareness of mental health, when and how to make a referral and how to support those people living with mental health issues. Training has also been provided to student nurses and healthcare assistants.

- 5.3.20 Although adult mental health practitioners do not receive regular, structured safeguarding children supervision they can access advice and guidance as and when required from the trust's safeguarding team. Cases of concern are also discussed at monthly team meetings.

Clinical supervision is structured and includes a request for practitioners to disclose all new cases where there are children who might be at risk. We saw that decisions made at clinical supervision sessions are appropriately recorded in client electronic records.

- 5.3.21 School nurses in Wokingham are no longer providing emergency hormonal contraception to young people in schools. The iCASH service recognises this as a gap and has provided training to pharmacies, as well as schools to ensure young people are appropriately cared for in the community.
- 5.3.22 All iCASH practitioners have accessed level three safeguarding children training. In addition, practitioners have accessed specialist training relevant to their role including CSE, and practitioners are encouraged to access LSCB training.
- 5.3.23 Currently a weekly 'education meeting' provides the opportunity for iCASH practitioners to discuss any cases of concern as a group and we saw that safeguarding was a regular agenda item. However, formal safeguarding supervision should to be available to all iCASH practitioners, particularly the outreach staff, to ensure they have protected time to discuss vulnerable and complicated cases, either as a group or one-to-one. **This issue has been drawn to the attention of Public Health, as the commissioners of the sexual health service.**
- 5.3.24 We were informed that all GPs have had multiagency level three safeguarding children training at some point in their career, with an expectation that GPs will access some form of safeguarding level three training every year, for a minimum of two hours.

GPs may find it advantageous to attend formal multidisciplinary level three update training sessions at regular intervals, as it is a good way of keeping up to date with current child protection issues both nationally and locally, as well as being informed about new policies, emerging evidence and research findings. (**Recommendation 4.4**)

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## Recommendations

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- 1. Wokingham CCG, The Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust should:**
  - 1.1 Strengthen and formalise arrangements for sharing information between GPs, maternity and the community health teams, including health visiting and school nursing, to ensure that multi-disciplinary exchange of information takes place for vulnerable children and young people or those at risk.
  - 1.2 Develop effective arrangements to quality assure initial and review health assessments for looked-after children placed out of area to ensure the assessments are conducted within agreed timescales and to a good standard.
  - 1.3 Develop systems to ensure that SDQ scores are incorporated into assessments and plans for looked after children to ensure that appropriate consideration is given to their emotional and mental wellbeing.
  - 1.4 Ensure that a stronger focus is placed on the early intervention and prevention of substance misuse in LAC assessments.
  
- 2. The Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust should:**
  - 2.1 Ensure that communication or liaison meetings between midwifery and health visitor teams are embedded to support consistent effective information sharing and cohesive multi-disciplinary practice.
  - 2.2 Work together to ensure that young people aged 16 to 18 who are seen in ED and then admitted to an adult medical ward following an episode of self-harm, receive a level of care and support which meets their needs.
  
- 3. The Royal Berkshire NHS Foundation Trust should:**
  - 3.1 Implement a system to quality assure the level of detail included in ED discharge summaries to ensure that GPs are receiving comprehensive information following a child or young person's attendance at the emergency department.
  - 3.2 Ensure women are made aware that they will be seen alone at least once during pregnancy and incorporate this into the antenatal appointment care plan to promote routine enquiry around sensitive issues including domestic abuse.

- 3.3 Develop a robust system to assure themselves that midwives are making appropriate enquiries about domestic abuse with all pregnant women to ensure vulnerable women are identified, offered support and where appropriate, safeguarding processes are instigated.
  - 3.4 Ensure that the quality of information shared by professionals in the adapted MARF effectively contributes to and strengthens the multi-agency safeguarding process
  - 3.5 Ensure that records in the maternity department are complete and include supervision records, safeguarding referrals, reports, minutes, plans and related documents so that the maternity team are able to make decisions on safeguarding of unborn or new-born babies based on all available information.
  - 3.6 Ensure that relevant safeguarding information is captured in the maternity electronic discharge summary so that community colleagues, including GPs, are fully aware of current safeguarding issues.
  - 3.7 Ensure that the safeguarding children training provision for maternity department staff meets the level, competencies and hours of learning as indicated in the intercollegiate guidance issued by the Royal College of Paediatrics and Child Health.
  - 3.8 Ensure that the safeguarding children supervision provision to midwives provides relevant staff with appropriate scrutiny and professional challenge and which also supports their development and confidence in undertaking safeguarding work. Ensure that agreed actions following supervision sessions are incorporated into in records.
- 4. Wokingham CCG and NHS England should:**
- 4.1 Ensure that GPs have access to robust templates which adequately aid their enquiries about CSE so they are better able to identify and safeguard children and young people at risk.
  - 4.2 Improve the working relationship between GPs and the adult substance misuse service to better ensure the safety of adult clients and prevent any negative impact on the safety of children or young people in their clients care.
  - 4.3 Provide advice and guidance to GPs on the appropriateness and benefits of highlighting information on children's health records about risks arising from adults in their household, particularly in relation to perpetrators of domestic abuse to ensure there is a standard approach to the recording of this information.

- 4.4 Review the safeguarding children training requirements for GPs and particularly named GPs to assure themselves that the training provision meets the competencies and level indicated in the intercollegiate document issued by the Royal College of Paediatrics and Child Health.

**5. Wokingham CCG and Berkshire Healthcare NHS Foundation Trust should:**

- 5.1 Continually monitor and review the ongoing work to reduce CAMHS waiting times and ensure that the projected target timescales are met so children and young people have good access to services.
- 5.2 Review the capacity of the designated nurse for looked after children to ensure the role can adequately meet the needs of the service, including quality assurance and development work. Ensure that until the reconfiguration of the service is complete, an appropriate service level agreement about the limitations and expectations of the role is in place.
- 5.3 Maintain progress towards meeting the quality standards and professional accountabilities for review health assessments as outlined in a recent CQC report (30/03/2016). Ensure any revised processes retain and promote a holistic child centred focus.
- 5.4 Review the capacity of the designated doctor for child protection to ensure that the needs of the service can be fully met and are sustainable.

**6. Bracknell and Ascot CCG and OneMedicalGroup should:**

- 6.1 Develop suitable paediatric liaison arrangements in the UCC that supports best safeguarding practice and effectively facilitates communication with community and primary care teams in order to ensure that potentially vulnerable children and young people are appropriately followed-up in the community.
- 6.2 Develop and implement a robust safeguarding assessment tool for use in the UCC to ensure practitioners are routinely assessing all children and young people's safeguarding needs. This will need to be audited to monitor compliance.
- 6.3 Ensure that the UCC receives information about vulnerable children and that practitioners are supported by a 'flagging' system which enables them to easily identify these children, including LAC and those subject to CP or CiN plans. This will facilitate effective sharing of information when a vulnerable child attends the UCC.



- 6.4 Ensure that adult documentation in the UCC includes appropriate prompts and trigger questions to support practitioners in assessing the potential for hidden harm to a child or young person when an adult presents as a result of risky or concerning behaviours.
- 6.5 Develop a safeguarding audit plan and undertake regular audits within the UCC to evidence effective safeguarding practice or to identify areas for improvement to better safeguard the children and young people who attend the UCC.
- 6.6 Ensure that the safeguarding children training provision for staff at the UCC meets the level and competencies indicated for unscheduled care staff in the intercollegiate document issued by the Royal College of Paediatrics and Child Health.
- 6.7 Ensure that practitioners at the UCC have access to regular safeguarding supervision in order to fully support their safeguarding practice on a day to day basis.

**7. Berkshire Healthcare NHS Foundation Trust should:**

- 7.1 Ensure that record keeping systems in CAMHS enable staff to have access to a complete record including safeguarding referrals, reports, minutes and plans so that practitioners are able to make decisions based on complete information to aid the effective safeguarding children and young people.
- 7.2 Ensure that training for CAMHS practitioners enables them to fully understand their role in the multi-agency safeguarding process and can confidently share their professional views and opinions.
- 7.3 Ensure that training for CAMHS practitioners includes training in CSE processes to make sure vulnerable children and young people are not only identified but that actions are then taken to safeguard them.
- 7.4 Ensure that in adult mental health services, care plans are complete records and include actions to be taken when it has been identified that a client has access to, or has parent or carer responsibility for children.
- 7.5 In adult mental health services develop the 'flagging' system on the electronic patient record system to ensure that all vulnerable children and young people of adult service users are easily identifiable.
- 7.6 Ensure that the CAHMS practitioner working in the 'Here for U' team has a job description which accurately reflects the role being undertaken.

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## Next steps

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

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.