

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

# Children Looked After and Safeguarding

## The role of health services in Dudley

<b>Date of review:</b>	23 <sup>rd</sup> May 2016 – 27 <sup>th</sup> May 2016
<b>Date of publication:</b>	20 <sup>th</sup> July 2016
<b>Name(s) of CQC inspector:</b>	Deepa Kholia-Mehta, Sue Talbot, Jennifer Fenlon, Emma Wilson, Elizabeth Fox
<b>Provider services included:</b>	Dudley Group NHS Foundation Trust Dudley and Walsall Mental Health Partnership NHS Trust Black Country Partnership NHS Foundation Trust Shropshire Community Trust
<b>CCGs included:</b>	NHS Dudley Clinical Commissioning Group
<b>NHS England area:</b>	Midlands and East Region
<b>CQC region:</b>	Central
<b>CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:</b>	Janet Williamson

## Contents

<b>Summary of the review</b>	<b>3</b>
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	7
<b>The child's journey</b>	<b>10</b>
Early help	10
Children in need	18
Child protection	23
Looked after children	30
<b>Management</b>	<b>34</b>
Leadership & management	34
Governance	39
Training and supervision	43
<b>Recommendations</b>	<b>50</b>
<b>Next steps</b>	<b>54</b>

---

## Summary of the review

---

This report records the findings of the review of health services in safeguarding and looked after children services in Dudley. 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 (Midlands and East of England).

Where the findings relate to children and families in local authority areas other than Dudley, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

---

## About the review

---

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2015*.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

---

## How we carried out the review

---

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

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

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

In total, we took into account the experiences of 67 children and young people.

---

## Context of the review

---

The majority of Dudley residents, 91.0% (291,940) are registered with a general practitioner (GP) practice that is a member of NHS Dudley Clinical Commissioning Group (CCG). A total of 47 GP practices operate across the Dudley borough.

Published information from the Child and Maternal Health Observatory (ChiMat) shows that children and young people under the age of 20 years make up 23.8% of the population of Dudley with 21.4% of school-age children being from a minority ethnic group. The proportion of children under 16 living in poverty is 21.3%, which is worse than England's average of 18.6%. However, the rate of family homelessness is significantly better than England's average.

The child health profile (March 2016) for Dudley indicates that on the whole health inequalities and outcomes of children and young people is mixed compared with England's average. For example, childhood vaccination levels for children, including those in care is better than the average for England. The infant mortality rate is similar to other areas in England. In addition, the proportion of children (aged 5 years) in Dudley with poor dental health is better than England's average of 27.9%, compared to 22.3% locally.

The rate of hospital admissions for children and young people as a result of self-harm is not significantly different to England's average; however, the rate of hospital admissions for mental health conditions is significantly better than England's average. The emotional and behaviour health of looked after children, which is captured within the strengths and difficulties questionnaires, is indicated to be normal and below the England average of 13.9.

In contrast the data shows that Dudley is significantly worse than England's average for 12 out of the 32 indicators identified in the child health profile. The percentage of children in reception (4-5 years) and Year 6 (aged 10-11 years) classified as being obese or overweight is significantly worse than England's average.

The data also indicates that the number of children in care, the % of mothers initiating breast feeding, as well as breastfeeding prevalence at 6-8 weeks after birth and the rate of under-18 conceptions per 1,000 females aged 15-17 years, is significantly worse than England's average.

In addition, the percentage of 16-18 year olds not in education, employment or training was significantly worse than England's average, whereas, the percentage of 10-17 year olds entering the youth justice system for the first-time is similar to other areas in England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children and young people continuously looked after. As at 31<sup>st</sup> March 2015, Dudley had 615 children and young people who had been continuously looked after for more than 12 months (excluding those in respite care). The data also indicated that 92.9% of looked after children and young peoples were up to date with their immunisation and 91.1% had received a dental check-up, which is better than the average for England at 87.8% and 85.8% respectively. However, in contrast recent data highlights that only 79.7% of looked after children in Dudley had their annual health assessments completed. This is lower than England's average of 89.7%.

Commissioning and planning of most health services for children are carried out by NHS Dudley Clinical Commissioning Group (CCG) and Dudley Public Health.

Commissioning arrangements for looked-after children's health are the responsibility of Dudley CCG. The designated looked-after children's nurse and the operational looked-after children's nurse/s are provided by Black Country Partnership NHS Foundation Trust and the designated looked-after children's doctor is provided by Dudley Group NHS Foundation Trust.

Acute hospital services are commissioned by Dudley CCG and provided by The Dudley Group NHS Foundation Trust. Our review included visits to the Trust's Emergency Department (ED), paediatric ward and maternity services.

Health visitor services, including the family nurse partnership programme are commissioned by Dudley Public Health and provided by Black Country Partnership NHS Foundation Trust.

School nurse services are commissioned by the Dudley Public Health and provided by Shropshire Community Health NHS Trust.

Contraception and sexual health services (CASH) are commissioned by Dudley Public Health and provided by Dudley Group NHS Foundation Trust with community services provided by Brook Dudley and the Dudley Respect Yourself Campaign.

Child substance misuse services are commissioned by Dudley Public Health and provided by Cranstoun, known locally as Switch.

Adult substance misuse services are commissioned by Dudley Public Health and provided by Change, Grow, Live (CGL), formally known as Crime Reduction Initiatives (CRI). The service is known locally as Atlantic House.

Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by Dudley and Walsall Mental Health Partnership NHS Trust, commissioned by Dudley CCG.

The last CQC safeguarding and looked after children's inspection of health services in Dudley took place in January 2012 as a joint inspection, with Ofsted. At that time, the overall effectiveness of the safeguarding services and the contribution of health agencies to keeping children and young people safe were judged as 'adequate'. The Being Healthy outcome area for looked-after children was also found to be 'adequate'. Recommendations from that inspection are covered in this review.

---

## The report

---

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

---

## What people told us

---

We spoke with some parents who had recently delivered a baby during our visit to the maternity service at the Russells Hall Hospital.

*“All midwives are caring and nice. When you press the buzzer they come straight to you even in the night and will answer all our queries. We were kept well informed”.*

*Another said: “Lots of positives about the care we have received – 99% of the staff were really good, with outstanding care shown by some, including explaining what is going on at all times. However, there were a couple of staff whose attitude did not display the high standard of care shown by the majority. The follow up care by the anaesthetist and the midwife was fantastic”.*

During our visit to the children’s Emergency Department (ED) at the Russells Hall Hospital, we spoke to a parent and her nine year old daughter waiting for assessment and treatment. They told us:

*“They have been really good here. We were seen quickly and they have kept us informed of what will be happening”.*

The parent also said: *“I wouldn’t take my kids anywhere else than here”.*

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

*“The health assessments are very good. My foster children can be seen at home or school and they are always seen for some time alone. I have a contact number for any questions and they are good at signposting children to services they can access themselves, like sexual health services”.*

*Another said: “Myself and any children I have cared for have always been given an option to have assessment at home or school, it’s been excellent. I feel I can ask for any help that I need – the looked-after children service provided adapted sexual health education to meet the needs of one of my foster children”.*

*Another said: “The children have always been given a choice about where they wanted to have their health assessment at home or school”.*

A foster carer also told us about their involvement with health plans for looked-after children in her care.

*“We receive copies of the health recommendations – this has never been a concern”.*

Another one said: *“I have always had a copy of the health assessment action plan and have been fortunate not to have needed much health intervention”*

We heard about the experience of one foster carer with the primary care service.

The foster carer said: *“It is very difficult to get a GP appointment. You have to call at 8am in the morning and most of the time you still cannot get an appointment – there is no preferential treatment for looked-after children. I worry about how my foster child will manage when she has to book her own appointments”*.

Another said: *“GP appointments are very difficult to get. There is no priority for looked-after children – I often go down with children and sit and wait, as it’s not possible to get through on the phone”*.

Another said: *“I have excellent access to the GP - All the foster children are able to access same day appointments if needed”*.

And another said: *“The support from my GP has been fantastic - I can always get an appointment and it’s never been a problem. I fostered two children with severe eczema and I was supported to attend a two day course”*.

We heard about the experience of a young mother with the primary care service:

*“My family nurse has helped me get appointments for my baby at the GP surgery, as you can never get an appointment. It can be really hard and I don’t like it when the receptionist starts asking lots of personal questions”*.

A young mother, with a 17 month old baby told us about her experience of the family nurse partnership (FNP) service.

*“This is a really great service – My family nurse is great and has supported me all through my pregnancy. I have enjoyed learning how to care for my baby. My relationship broke down and she gave me advice when I didn’t feel I could turn to my family”*.

She also said: *“It would be better if all mums got offered the FNP service, as it helps you to understand and make choices about breast feeding and weaning. The FNP will help with everything to make mine and my daughter’s life better – Like getting a house and going to college to do my maths and English. I know my family nurse will be there to support me no matter what”*.



We also heard about experience of the CAMHS service from foster carers that we spoke to.

*“As a foster carer, I was offered consultation to support my child – This worked very well and CAMHS monitored through this. Transition planning to adulthood has been excellent for the 18 year old in my care and she has been supported to gain a place at university in September”.*

*Another said: “CAMHS has been a real challenge – They stopped my foster son’s ADHD (attention deficit hyperactivity disorder) medication, as he was approaching 18 years. They told us that ADHD was a childhood disease. This left my foster son very agitated and anxious. This significantly started affecting his daily life. We saw another practitioner who restarted the medication. We are now awaiting for a referral to the adult mental health services”.*

*Another one said: “My 18 year old foster child has moderate learning difficulties, ADHD and autism. There are lots of assessments happening for transitioning into adult services. Despite three key people being involved, it’s been confusing for me so I worry how it must be for him”.*

*And another one said: “CAMHS are very, very difficult to access. They seem too busy. They do not offer any advice on the telephone and I worry some children fall through the net. I had concerns for a child with poor social skills – I felt he was on the autistic spectrum but they did not care as he was ok academically. He really struggled at transition because he had not had the correct assessment or support”.*

---

## The child's journey

---

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

---

### 1. Early help

---

1.1 Midwives employed by the Russells Hall Hospital take a flexible approach to conducting antenatal appointments in a number of locations, including primary care and children's centres. This helps to facilitate early engagement with the service.

1.2 Women in Dudley benefit from good liaison between midwives and GPs at the point of booking. For example, midwives record contact with pregnant women in GP records, which means that GPs have access to important information relating to all pregnant women on their caseloads, particularly those who are vulnerable. In addition, the named midwife appropriately alerts partner agencies and the trust safeguarding lead when a young person presents late in their pregnancy.

**Case Example:** Concealed pregnancy of a vulnerable 16 year old girl.

The young person presented for booking very late in her pregnancy, which immediately alerted the midwife to her potential vulnerability. An urgent referral was made to the hospital maternity services, with good liaison maintained between the midwife and the GP. The GP raised concerns about the young person's mental health, which resulted in a referral being made to the child and adolescent mental health service (CAMHS).

The young person attended the hospital for her scan and blood tests but was sent home before being seen by the obstetrician and named midwife. This was promptly identified and followed up by the named midwife who contacted the young person so she could be seen the following day. The midwifery health records of the young person demonstrated that the named midwife sensitively gathered additional information, including identification of the father and the young person's wishes in relation to his attendance at the birth. The information was appropriately shared with relevant others including the trust safeguarding lead, the Respect Yourself young person's support service and children's social care.

**Outcome:** The young person has had help progressing with her education and she is engaging well with support services to address future contraception and sexual health needs in order to avoid further unintended pregnancies.

1.3 Midwives and health visitors meet monthly to discuss vulnerable pregnant women on their caseloads. In addition, health visitors attend the monthly midwifery led unborn baby network meetings for safeguarding cases on a rotational basis. This multi-agency forum enables health visitors to share information to help support vulnerable pregnant mothers. However, the sharing of key information from midwives to health visitors is largely dependent on verbal handover with limited focus on risk. This means that important information might be missed. We were not assured that this approach was sufficient in ensuring continuity of care for vulnerable women and their babies. (**Recommendation 1.1**). This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.

1.4 The midwifery service has recently focused their attention on the provision of early help for pregnant women in Dudley, for example, strengthening common assessment framework (CAF) work. However, it is still at an early stage of development and requires a shared and jointly owned approach across all frontline health professionals. Referrals for early help are now being monitored through the safeguarding dashboard which should help to strengthen practice in this area.

1.5 The family nurse partnership (FNP) service is a licensed programme which aims to safeguard two of the most at-risk and vulnerable population groups, teenage mothers and their children, through early intervention and preventative work. In Dudley, the FNP programme has been running for over three and a half years and is well established. Approximately 75% of young people referred to the service are accepted onto the FNP programme. However, the service manager recognises that not all young people in Dudley that need the FNP service will qualify due to the eligibility criteria. This has been recognised as a gap locally and a teenage parenting service provided by 'Respect Yourself' is offered to all teenage mothers who are assessed as not being eligible or for those opting out of the FNP service. This is a positive development as it helps ensure that additional support is available early on for those that need it the most, and that children of young mothers in Dudley have the opportunity to reach their full potential.

1.6 In Dudley, families and children under the age of five benefit from good delivery of the 'Healthy Child Programme' (HCP) provided by the health visiting service. This includes a new birth, a six week visit and a development review at one year of age and again at two years. In addition, families are offered an antenatal visit, which enables professionals to identify and assess needs, as well as intervene and provide early help to families that require it. However, we were informed that, in Dudley, only 70% of mothers have been offered an antenatal visit. This is predominantly due to midwives, attached to GP practices outside of Dudley not sharing information with the health visitors. The health visiting service has identified this as an area for development.

1.7 There is good communication between the health visiting and adult substance misuse team; however, this is predominantly for children who are subject to child protection plans. Adult substance misuse practitioners do not routinely contact health visitors to notify them when a parent is registered with the service. Therefore, health visitors may not always be aware that the adult substance misuse service is involved with a family and this is a missed opportunity for early intervention work. This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse and health visiting service.

1.8 The school nursing team in Dudley has good capacity to deliver the HCP for children aged 5 – 19. In addition, it is well-resourced with a team of mixed skills, including a mental health qualified nurse. The mental health nurse provides good support to the wider school nursing team and as a result the team are well placed to offer a good Tier 2 CAMHS provision. This includes packages of support for children and young people with a history of self-harm, low mood and anxiety. However, the school nursing team are not yet fully integrated with CAMHS and partnership working requires strengthening. This has been identified as a gap locally and meetings are being held to integrate the service offer. It is envisaged that this will positively impact and strengthen the CAMHS service offer in Dudley, thereby reducing the high levels of emotional health and well-being needs of children and young people.

1.9 Referrals into CAMHS are made through GPs and children's social care. We saw CAMHS referrals completed and appropriately scanned onto electronic patient records during our visit to a GP practice. GPs we spoke to reported challenges with accessing Tier 2 CAMHS provisions locally. However, they reported that CAMHS were responsive to acute situations and that the enhanced practitioner pathway worked effectively. During our visit to CAMHS, we found that the service offers a timely response to referrals in line with their red, amber, green (RAG) rating system. Screening of risks is clear and timescales for appointment are appropriate to urgency, with sufficient capacity to call appointments forward should risks escalate. Time from assessment to treatment is in line with levels of risk and target timescales. Cancellations and 'did not attend' (DNAs) are clearly recorded with alternative appointments promptly offered.

1.10 The school nursing service offer is also available to children and young people who are home educated or not in education. This helps ensure that vulnerable children, young people and their families receive support that is appropriate to their needs. This is important as it is well known that children and young people not in education, employment or training are a vulnerable population group who experience the worst health outcomes.

1.11 School nursing teams in Dudley receive a domestic abuse response team (DART) notification for all low and medium risk domestic abuse incidents from the safeguarding children's team. However, school nurses reported that a detailed account of what occurred at the incident is not always provided. This is identified as a shortfall in current practice as it prevents school nurses from suitably risk assessing prior to visiting vulnerable families at home. We were informed that outcomes from DART discussions and any intervention required is shared with school nurses; however, school nurses that we spoke with reported that outcomes are not routinely shared. This perceived lack of information sharing is preventing the school nurses from offering therapeutic support to children and young people should they present at a drop-in clinic, thereby reducing the opportunity to provide early help.

1.12 All school nurses are based within local schools in Dudley and contribute to the delivery of puberty and sexual health classes as part of the educational curriculum. In records reviewed, it was evident that school nurses are visible and easily accessed by children and young people. However at present, school nurses do not offer a contraception and sexual health service (CASH) to school-aged children and young people, despite having previously received training to undertake chlamydia screening in schools. We heard of plans to link CASH services into school nursing by September 2016, which will strengthen the CASH service offer in Dudley. This is important as teenage pregnancy rates remain high locally and young people are more likely to access support from services if they are delivered by professionals with whom they have regular contact.

1.13 To address the high rates of teenage pregnancy and repeat unintended pregnancies in Dudley, the CASH outreach nurses have been working closely with the midwifery service by attending their weekly drop-in clinics. This enables them to provide targeted CASH advice and support for all under 25s. In addition, a gap identified locally is the provision of support available for vulnerable boys and men. As a result, a young males parenting group has also been established, which is aimed at addressing unintended repeat teenage pregnancies through targeted education which will empower young males to make informed future decisions. This is a positive development and shows that the CASH service in Dudley are proactive in responding to emerging local needs.

1.14 Young people in Dudley have good access to a CASH and genitourinary medicine (GUM) service, which is delivered by a number of providers including Dudley Group NHS Foundation Trust (DGFT) and community services by Brook and Respect Yourself. Additional support is also available through local pharmacies, which provide emergency hormonal contraception (EHC) and GP practices that offer a range of CASH services. The CASH service has established effective systems whereby pharmacies providing EHC can fast track young people for additional sexual health advice and support from hospital based or local CASH clinics. The Respect Yourself team are flexible in their approach when offering appointments to vulnerable young people in order for them to access the service. This means that young people can receive sexual health advice and support in locations or venues that are easily accessible by them.

1.15 The GP practice that we visited has access to a sexual health and contraception template that is available on the electronic patient records system. However, in records reviewed we saw no evidence of it being used in practice. GPs are in an ideal position to notice early signs of child sexual exploitation (CSE) when children and young people present for sexual health advice and support if they are alert to possible indicators. Therefore it is important that, as part of their assessment, GPs use the Fraser guidelines and consider additional vulnerabilities. This would include identifying the number of previous sexual partners, concerns about domestic abuse, mental health or alcohol and substance misuse. This would better support GPs to consider and recognise those children and young people who are at risk of CSE. (**Recommendation 2.1**).

1.16 The paediatric emergency department (ED) at the Russells Hall Hospital sees children and young people up to the age of 16. The department has a small, dedicated area consisting of 3 cubicles and a separate waiting area, which is in good sight of nursing staff. This means that any children and young people with a deteriorating condition can be identified promptly. In addition, any observations pertinent to safeguarding can be fully assessed.

1.17 Comprehensive demographic details are obtained and recorded by reception staff for all children and young people attending the ED. This includes information about ethnicity, religion, GP details, next of kin and registered school. Recording basic demographic details is important as it can also help ensure that ED practitioners have access to readily available information to inform their initial assessment of a patient and to inform how best health care support can be delivered. It further helps ensure that children and young people have access to culturally sensitive care as required.

1.18 The ED has an electronic flagging system to alert practitioners if a child or young person has been or is currently subject to a child protection plan. It is easy for the practitioner to explore further the reasons behind the electronic flag and use this information as part of their assessment. However, children or young people looked-after or at risk of CSE are not currently being flagged. In addition, ED practitioners are not invited to attend the local young people at risk of sexual exploitation (YPSE) meetings, where important information about those at risk of CSE can be gathered. As the front door service into health, ED practitioners are in a key position to identify children and young people at risk of CSE and thereby prevent further harm. Therefore, it is important that the ED is represented at these meetings, so that patient records can be updated accordingly. (**Recommendation 3.1**).

1.19 Children and young people aged 16 and under, who attend the ED benefit from a safeguarding triage assessment, which is a mandatory field on the ED electronic patient records system. However, there is an overreliance on individual professional curiosity and for practitioners to identify additional vulnerabilities, such as those presenting with risk taking behaviours, in a mental health crisis and alcohol or substance misuse. Older children and young people attending the ED do not routinely have their vulnerability considered alongside their clinical presentation. All 16 to 18 year olds attending the ED are seen in the adult ED but where possible they are given a choice of where they would like to be seen for their assessment and treatment. There is no separate paperwork for this age group in the adult care environment; however, where additional vulnerabilities have been identified the dedicated paediatric paperwork will be utilised. This means that ED practitioners will not be able to assess for additional vulnerabilities and in particular those children and young people who may be at risk of CSE. This is a missed opportunity for ED practitioners to identify the need for early help and support and make appropriate referrals (**Recommendation 3.2**).

1.20 All non-ambulant babies under one year old, who attend with head injuries are treated in accordance with the National Institute for Health and Care Excellence (NICE) guidance. However, there is no formal trust protocol to ensure that they are reviewed by a senior paediatric middle-grade doctor or paediatric consultant, unless they are to be admitted to the paediatric ward for further assessment or observations. We were informed that all junior ED doctors are encouraged and advised to discuss cases with a senior ED doctor before discharging a child home. ED practitioners have good access to a paediatric registrar 24 hours a day for seven days a week, for advice and guidance. However, the current arrangements mean that infants are not being assessed by an appropriately trained medical professional and the significance of the presenting injury may be overlooked as a result. (**Recommendation 3.3**).

1.21 ED practitioners reported that medical history from the child or young person is taken during assessment. However, we saw no evidence of the voice of the child or young person reflected within the records reviewed. Collecting history from children and young people where possible is important. This is because some parents or carers may conceal key information which can support ED practitioners with essential decision making, as well as ensure that the most appropriate action is taken to safeguard vulnerable children and young people. (**Recommendation 3.4**).

1.22 There is an expectation by the trust that a paediatric liaison form is completed by ED practitioners where additional child safeguarding concerns have been identified during the formal assessment process. Although the paediatric nurse function is not a mandatory role, it is recognised as a highly valuable safety mechanism for minimising the risk of harm to vulnerable children and young people when it is effectively utilised in an acute setting. In cases that we sampled, we saw evidence that not all safeguarding concerns were being appropriately referred to the paediatric liaison nurse (PLN) as set out in the referral criteria. It is recognised that the PLN does not have capacity to extend into the adult ED and therefore there is no review to act as a “safety net” of those adults who attend with risk taking behaviour. Therefore, we could not be assured at the time of our inspection that all cases of concern are being recognised following attendance at the ED and are therefore being directed for appropriate care and support (**Recommendation 3.5**).

1.23 At the point of discharge, ED practitioners do not automatically send discharge summaries to health visiting and school nursing teams. However, the PLN at Russells Hall Hospital is responsible for reviewing all under 18 attendances. The current system enables the PLN to send health visitors additional information for all under five attendances, regardless of the presenting complaint. However, school-aged children in Dudley (aged five to 19) do not benefit from the same information sharing system. GPs are automatically sent information of ED attendances; however, the information included is limited to the time of attendance and the presenting complaint or the diagnosis. Therefore, important information, such as, the mechanism of injury, is not included in the summary and this is a missed opportunity to ensure the GP can identify accurately any follow-up actions or early help and support that the family may require. It is important that GPs, as well as school nurses, are sent detailed discharge summaries for those on their caseload, as they will then be better informed and in a position to consider the full details of the ED attendance in the context of the child or young person’s overall health needs. (**Recommendation 3.6**).

1.24 Children and young people who attend ED at Russells Hall Hospital following an incident of alcohol or substance misuse are automatically referred to the local substance misuse team, known as ‘Switch’. ED practitioners informed us that they have worked in close partnership with the substance misuse service, who will accept all referrals including those where consent has not been given. This is good and means that vulnerable children and young people will have timely access to help and support at the earliest opportunity. However, we could not be assured that ED practitioners are routinely completing the Switch referral form, as in one record reviewed there was no evidence of a referral being completed, despite the young person attending with a substantial alcohol overdose. (**Recommendation 3.7**).



1.25 The adult substance misuse service is starting to embed the 'think family' model in their day-to-day work. In case records reviewed, it was evident that practitioners consider the 'hidden child' during their assessments, as home visits are carried out for children where there are known concerns. Details of any observations and interactions are recorded on the safeguarding module available on the electronic patient records system. This helps ensure that children living in the homes of risk-taking adults are identified, better safeguarded and protected from harm. However this practice could be strengthened further by recording meaningful analysis of how children present and interact around the adult whom they are with, even when there are no known concerns. This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.

1.26 GPs do not document the full name and relationship of the adult accompanying the child or young person to their appointment on the electronic patient records. This needs to be strengthened, as it can help identify who has parental responsibility but also because failing to record the full details of parents or carers has featured in serious case reviews. In addition, GP records we saw did not reflect the voice of the child or young person. We saw no evidence of GPs asking young people if they would like to be seen on their own, when they attend with their parents. This is important particularly when discussing more sensitive issues, for example sexual health or emotional health and well-being. (**Recommendation 2.2**).

1.27 Dudley introduced a new multi-agency safeguarding hub (MASH) in May 2016, to provide a single point of entry for referrals by professionals who had safeguarding concerns about children, young people and their families. The MASH currently has a health representative three days a week, with plans to extend health input to five days with an additional full-time post to increase the capacity for information gathering and support decision-making. Information is currently gathered from a number of health professionals; however a decision has been made to not contact GPs for information that they may hold. We were informed of plans to complete some preparation work with GPs to create smooth processes for sharing information with the MASH but there is no time frame for when this work will commence. (**Recommendation 2.3**).

---

## 2. Children in need

---

2.1 The unborn baby network meeting, chaired by the named midwife and set-up by the midwifery service is now well established in Dudley, with membership from a wide range of health and social care professionals. This meeting enables proactive sharing of information, joint exploration of concerns and helps inform shared awareness of risks. This enables each individual professional group to develop a holistic risk management plan. In addition, these meetings have had a positive impact on maximising the care and support and improving the health and wellbeing of pregnant women and their unborn or new born babies. As well, they have the potential to reduce the likelihood of a child requiring statutory intervention at birth.

2.2 The CCG recognise that they are not compliant with the Department of Health (DH) guidance in terms of providing specialist perinatal mental health support for women with mental health concerns in their pregnancy. Although there is a specialist midwife, whose portfolio includes mental health, there is a gap in the local provision of support available for vulnerable pregnant women with mental health needs. (**Recommendation 4.1**).

2.3 A perinatal mental health assessment is routinely undertaken by health visitors at the antenatal, new birth and six-eight week review. This helps to identify vulnerable mothers with mental health needs and thereby facilitate early engagement with services. If concerns are identified by health visitors, mothers are offered six listening visits. In addition, if specialist intervention is required the GP will refer to mental health services. However, a health visitor we spoke with reported that this has been a barrier as thresholds to access mental health services are high; therefore, many mothers are being seen by third sector services, such as MIND. This requires further development to ensure mothers get appropriate support they require at this vulnerable time. (**Recommendation 4.1**).

2.4 Vulnerable families or children and young people in Dudley do not always receive a co-ordinated approach to their care involving primary care and community health practitioners. All GPs in Dudley have a health visitor attached to their service; however, those Dudley residents with a GP outside of the area are attached to a health visiting service within their geographical boundary area. In some GP practices, health visitors are invited to attend monthly meetings with GPs to discuss safeguarding and vulnerable cases. During our inspection, we found that this practice is variable. One GP practice that we visited keeps a list of all the safeguarding cases that have been discussed at the liaison meeting, but outcomes following discussion are not being documented within the patient electronic records. This is important as it can help GPs, as primary record holders, to monitor progress and improve outcomes for children, young people and their families, particularly vulnerable families through the use of current, relevant information. (**Recommendation 2.4 and 5.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.

2.5 In the absence of formal GP led face-to-face multidisciplinary liaison meetings, midwives and school nurses rely on informal arrangements such as *ad-hoc* opportunities and whenever midwives are present at clinics held at GP practices. GPs hold essential information about patients' current and historical health and social issues which may have an impact on parenting capacity, so accessing this information is an essential part of risk assessing potential harm to children and young people. Not holding multidisciplinary liaison meetings is a gap as professionals do not have the opportunity to ensure that vulnerable families or those with more complex needs receive a co-ordinated approach to their care. **(Recommendation 5.1)** This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.

2.6 There are a number of specialist health visitors in Dudley who respond to the needs of the local community and certain population groups. In particular, a specialist health visitor has worked closely with the local Gypsy, Roma and travelling community enabling them to have timely support to universal services by facilitating GP appointments, immunisations and education sessions. The specialist health visitors in Dudley are available to the wider health visiting team for advice and support. Health visiting teams are also effectively supported by community nursery nurses, who provide packages of care for families requiring support with behaviour management concerns. A well-resourced health visiting service can help ensure that vulnerable families have a positive start and access to a strong, yet safe service offer.

2.7 In cases reviewed, we saw evidence of school nurses being persistent in ensuring that children and young people were able to appropriately get access to services in order to support their identified needs. For example, in one case sampled we saw how the school nurse worked closely with the community paediatrician to ensure that the young person had access to the care and support that they required for their emotional health and wellbeing, from CAMHS. However, liaison with GPs requires strengthening as indicated above. School nurses rely on their professional discretion to share information. Appropriate sharing of information between professionals has considerable benefits for the development and improvement of health outcomes. In addition, a lack of effective communication, direct liaison and information sharing between practitioners involved with a vulnerable child or family is a feature of serious case reviews (SCRs). **(Recommendation 5.1)** This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.

2.8 During our visit to CAMHS, we found good joint working with GPs, school nurses and parents in order to try and address long-standing serious health concerns. In addition, CAMHS practitioners have robust escalation system in place to flag risks and raise concerns. This helps to ensure safe outcomes for vulnerable children and young people. Some of the complex CAMHS cases are co-worked between clinicians and a CAMHS support worker, thereby making best use of clinical expertise and case co-ordination activity. However, in one case seen the absence of social care input in CAMHS was a significant gap in terms of providing the level of therapeutic support that a family required in keeping their child safe.

2.9 DNA rates for CAMHS appointments are generally low. A number of positive actions have been taken to raise awareness and to maximise engagement with the service by further reducing the DNA rate. For example, reminder posters containing performance data in terms of DNA rates have been displayed in CAMHS clinic waiting rooms. The purpose of these posters is to promote awareness and the impact of delaying treatment on children and young people. In addition, CAMHS have introduced a text messaging service, whereby young people and families can be sent reminder text messages of CAMHS appointments, should they wish to be contacted in this way.

2.10 CAMHS managers are vigilant in managing waiting lists and in April 2016, the longest waiting period was seven weeks from assessment to treatment. In addition, young people with eating disorders are seen within the NICE guideline timescales. This is important as early action reduces the long-term impact on children and young people. This is because it improves health outcomes and minimises the impact on other aspects of their development, such as their education, thereby also improving their wider social development outcomes.

2.11 CAMHS deliver a crisis response service, which is aimed at protecting those children and young people who present at the ED with an acute mental health need, during the hours of 9am-5pm. However, we found that the support on offer by CAMHS for those children and young people under the age of 16 who attend with self-harm, following an over dose, in a mental health crisis or with risk-taking behaviour requires strengthening. Dudley and Walsall Mental Health Partnership NHS Trust reported that they had plans to develop this work with the ED. However, until then children and young people have their physical health needs assessed within the ED before they are transferred to the paediatric ward to wait for a CAMHS assessment, which usually takes place the following morning unless that crisis response service have received the referral before 12:30pm.

2.12 For example, during our visit to the ED a young boy presented in a mental health crisis. The ED practitioners appropriately contacted the CAMHS crisis team during the service operational time to request an assessment; however they were advised that the child would not be assessed until the following morning. Therefore, the child was admitted to the paediatric ward, to await an assessment. We were informed that it is routine practice to admit all children and young people requiring a CAMHS assessment to the paediatric ward, irrespective of the level of need or risk. Therefore, those children and young people requiring CAMHS support in Dudley are currently not benefiting from a rapid assessment. The current arrangements mean that some children and young people are being kept inappropriately in hospital. In addition, we heard that those children and young people requiring a tier 4 urgent care bed are facing unnecessarily long stays in the hospital. (**Recommendation 6.1**).

2.13 During our inspection, those children and young people with mental health needs who are transferred to the paediatric ward for further medical intervention or to wait for a CAMHS assessment did not benefit from a formal risk assessment; either for the risk that they pose to themselves or to others on the ward. Their physical environment was also not assessed to ensure that it was safe and appropriate for their needs. However, we were informed that a formal risk assessment, checklist and care plan was being developed. This will help ensure that those patients who are admitted for a CAMHS assessment are better safeguarded, whilst also ensuring that the diverse needs of all children and young people, including any visitors to the ward is effectively managed. (**Recommendation 3.8**).

2.14 There is no out of hours CAMHS provision in Dudley, with support only available Monday-Friday. CAMHS practitioners from the crisis team will visit children and young people daily and write their assessment within the nursing notes held on the ward. However, a copy of their care plan is not shared with paediatric ward practitioners, which would help guide them whilst vulnerable young people are resident on the ward. This is not acceptable, particularly given that children and young people are being held inappropriately for lengthy periods of time of the paediatric ward. (**Recommendation 6.2**).

2.15 Access to tier 4 urgent care beds remains a challenge for children and young people in Dudley. In one case that we looked at, a vulnerable young person was placed on an adult ward. However, the adult mental health service were vigilant in monitoring and clearly identifying how the young person presented and made sure that the needs and risks of this young person were assessed and met. At the same time the service effectively liaised with the planned tier 4 provision to ensure there was a smooth transition. However, there is more work to do to ensure that adult mental health practitioners appropriately flag electronic health records to identify vulnerable young people, which would immediately alert other practitioners to consider additional vulnerability during assessment. (**Recommendation 4.2**).

2.16 Adult mental health services appropriately alert children's social care when children under the age of 18 are admitted onto an adult psychiatric ward. In addition, the trust alerts children's social care when parents are admitted, as well as when they are discharged from psychiatric care. This helps ensure that risks affecting vulnerable children and young people arising from parental mental ill-health on discharge are highlighted and children's social care can take necessary steps to mitigate any risks.

2.17 Our review of adult mental health records demonstrated good joint working with partners to support vulnerable woman with a complex history. In one case that we looked at, we saw evidence of the community psychiatric nurse (CPN) liaising with partner agencies about historical concerns, to enable safe care to be provided to an unborn baby. The outcome of this joint working was that the mother's parenting capacity was strengthened by supporting her engagement with a number of support groups.

2.18 The FACE assessment used by adult mental health practitioners asks questions as to whether the adult patient has dependent children or regular contact with children. The practice could be strengthened by including more details; for example, names, dates of birth and care arrangements.

**Case example:** Good joint working by adult mental health service to support mother with complex health history.

The adult mental health practitioner effectively supported a pregnant woman who had a history of domestic abuse, mental ill-health and substance misuse. The father of the unborn baby also had offending history in relation to domestic abuse, although it was reported that this relationship had ended.

When the adult mental health practitioner became aware of the pregnancy a professionals meeting was held involving mental health services, the named midwife and the substance misuse service. Children's social care also became involved in a more recent meeting once the woman's pregnancy had reached 20 weeks.

The CPN has established an open and trusting relationship with the woman and recognises her vulnerability and her limited literacy skills. A clear risk management plan was put in place as her due date approached. Mother's voice was sensitively captured within case records, which showed good support from the CPN to help her demonstrate the changes she was making to strengthen her parenting capacity. Mother-to-be was encouraged to engage with the independent domestic violence advisor and the 'Freedom' programme to address domestic abuse issues and the impact on her decisions.

**Outcomes:** The mother-to-be was supported to move to a safe house, to cease misusing drugs or alcohol and to become less chaotic. The joint work and support of the midwives and the mental health service, with consultant oversight, has enabled the woman to make progress to reach her goals of reducing her medication and, ultimately, parenting the new baby.

2.19 Adult ED practitioners are not sufficiently rigorous in identifying safeguarding risks to children or young people where adult patients attend the department following an incident of domestic abuse or self-harm, or with mental ill-health or substance and alcohol misuse problems. In all cases sampled, we saw missed opportunities by ED practitioners to collect information such as details of other children and young people within the household and any caring responsibilities that the adult patient may have. There is more work to do to ensure that the 'think family' principles are embedded within practice; for example, by including appropriate prompts in the adult ED assessment pro-forma to help practitioners collect this information. The current arrangements are too variable and there is an over-reliance on the knowledge, experience and professional curiosity of individual practitioners to ask the right questions. (**Recommendation 3.9**).

---

### 3. Child protection

---

3.1 All referrals to children's social care are sent through the MASH. However, not all health information is being shared on time to inform the RAG rating system, which could help identify risk and inform safeguarding concerns. Information provided by the MASH health nurse does not contain any analysis of risk that would ordinarily support partner agencies with decision-making. This has the potential to lead to inaccurate risk assessments. We recognise that the MASH system in Dudley is still in its early development stage. However, as part of the continued development of the MASH, health agencies would benefit from clearer and more robust arrangements for the collection, analysis and oversight of information. This will ensure that information is presented in a way and within a timeframe that is of value to the MASH. (**Recommendation 7.1**).

3.2 At Russells Hall Hospital, midwives have a clear pathway for the management of notifications of domestic abuse, with appropriate follow up by the specialist or named midwife. In addition, the midwifery service is well represented at multi-agency risk assessment conference (MARAC) meetings. This is important as research shows there is an increased risk of first time incidence of domestic abuse during pregnancy. In addition, attendance at MARAC meetings provides an opportunity for the midwifery service to gather important information in order to safeguard unborn babies.

3.3 There is managerial expectation that midwives should routinely ask about domestic abuse at different points in the pregnancy, as well as postnatally. However, in records sampled we found that domestic abuse checks were inconsistently recorded and all evidenced the question only being asked on one occasion. Guidance from the Royal College of Midwives states that domestic abuse questions should be asked at different points during a pregnancy as abuse poses a significant threat psychologically and physically to both women and their unborn baby. Therefore, the current practice needs to be further strengthened to increase vigilance in this area to ensure domestic abuse that emerges or escalates through the pregnancy is identified. (**Recommendation 3.10**).

3.4 Focus on and awareness of professional accountabilities for reporting incidents of female genital mutilation (FGM) is good within the midwifery service in Dudley. We heard that reporting is increasing and complies with requirements for recording incidences. In addition, there is good documentation in place to support the pathway for women identified with FGM. The midwives we spoke with know their local populations at risk. This also includes those women at risk of being trafficked. We heard that senior midwives are working at a strategic level in the West Midlands to share intelligence and proactively support women and children at risk. The specialist midwife also leads the FGM agenda from a clinical perspective in Dudley.

3.5 Midwifery case records sampled provided a clear and strong focus on risk, with appropriate management of incidents of concern. Prompt action is also taken to alert children's social care about a number of safeguarding concerns, including woman who are late booking their pregnancy, those who have a history of depression and who are socially isolated. We saw evidence of good joint working and management of a mother with mental health needs, with appropriate safeguards put in place until she could be transferred for the specialist mental health care that she required. This demonstrates that midwives are working proactively in order to safeguard vulnerable mothers-to-be and their unborn babies.

3.6 Although midwives routinely refer to children's social care where they have identified safeguarding concerns or risks, the quality of such referrals could be strengthened through a sharper focus on analysis, including parenting capacity and the impact on the unborn or new born baby. In particular, only basic information was provided about the father in most cases seen, and indicates the need to be more professionally curious about the absent father. This is important for supporting partner agencies with decision making to safeguard unborn babies. (**Recommendation 3.11**).

3.7 Midwives are encouraged to attend safeguarding meetings, and in cases sampled we saw evidence of good representation of midwives at child protection conferences and core group meetings, with appropriate liaison with other partner agencies. Attendance of midwives at safeguarding meetings is vital, so that they can contribute their professional expertise and knowledge.

3.8 Health visitors demonstrate good professional curiosity in the identification of risk and potential disguised compliance. They also have good understanding of how to make referrals to children's social care. However, in one case sampled we saw that the health visitor had made a referral by telephone but had failed to follow this up in writing. This is important safeguarding practice as it ensures a clear shared record and accountability of decision.

3.9 Health visitors and school nurses have a single point of access where invitations for all child protection conferences and core group meetings can be sent. This is good and helps ensure that that the respective services are well represented. There is an expectation that health visitors will attend all initial, review and core group meetings and produce a report to present at conference. A standard pro-forma is used by health visitors and school nurses for child protection conference reports. Although they were completed to a reasonable standard, we found from cases sampled that the reports lacked analysis and articulation of risk. They also failed to reflect the proactive and child focused work that had taken place by the health professional. In addition, we also saw case examples where referrals to children's social care and conference reports were not filed in health records. This means that a complete set of medical records, which can support ongoing decision making about risk was missing in some cases sampled. (**Recommendation 8.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.



3.10 School nurses are required to attend all initial child protection conferences. A health assessment is completed in order to help identify any health needs. However, school nurses do not currently use a standardised health assessment pro-forma. This is important to support them complete a holistic assessment and in order to target SMART health interventions according to identified needs. Senior managers at Shropshire Community Health NHS Trust (SCHT) have recognised this as a gap, and we heard of plans to implement a formal health assessment pro-forma that can be utilised by all school nurses.

3.11 School nurses demonstrate good professional curiosity and commitment to safeguarding vulnerable children and young people in complex cases. In one case sampled, the school nurse demonstrated persistence in contacting children's social care and initiating a formal escalation process for a vulnerable young person at risk of CSE. The school nurse also appropriately challenged a decision made at conference. This shows that the school nurse had good knowledge of the needs of the young person and was actively engaged in decisions that supported good outcomes for the young person.

3.12 The school nursing service in Dudley is well represented at the YPSE meetings. School nurses reported good awareness of the Shropshire CSE risk assessment tool. However, there is more to do to ensure that the service fully understands its important role in risk assessment, identification and follow-up of potential CSE cases, particularly as there are plans to implement CASH services at school-drop-ins in the near future. (**Recommendation 9.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.

3.13 In contrast, CAMHS record shows outstanding practice by clinician in alerting children's social care to CSE risks. The CSE tools were effectively used by the CAMHS practitioner to highlight risk or any concerns.

**Case Example:** A young person known to the CAMHS service, who is at risk of CSE.

A 15 year old girl of mixed heritage disclosed to her CAMHS worker that she had been sexually abused. The CAMHS practitioners completed a CSE risk assessment tool, which highlighted a range of significant and medium risks. These were in relation to internet safety, being seen with unknown males, missing from home, unprotected sex on at least one occasion and using alcohol and drugs combined with lack of understanding or insight by the young person into the risky situations that she was putting herself in. The CAMHS practitioner promptly alerted children's social care of the disclosure and has continued to support the young person and her family in managing anxiety and low self-esteem whilst meeting her other significant mental needs at the same time.

**Outcomes:** The young person has continued to engage well with CAMHS. Her risk management plan clearly identifies a range of issues, supported by strategies for managing them and keeping the young person and her family at the centre of the process, whilst the CSE risks are followed up by the police and social services.

3.14 Interagency referral forms to children's social care are routinely prepared when CAMHS practitioners identify children, young people or their family who would benefit from additional help or where risks to their safety are escalating. In cases samples, we saw CAMHS practitioners appropriately engaged in child protection and child in need work. This work is given a high priority with conference reports prepared in a timely fashion.

3.15 The CAMHS child protection consultation service provides 'a fresh pair of eyes' and supports social workers working with young people on child protection plans or those at risk of CSE. This enables clearer recognition of risks to the young person, their emotional and mental wellbeing, as well as developing and reviewing strategies to help keep them safe. This is further supported by the high quality of work that is undertaken by CAMHS practitioners to safeguard vulnerable children and young people. This is achieved by effectively making good use of the knowledge, skills and experience of the respective team members in providing a strong child centred overview of family dynamics and risks.

3.16 CASH services in Dudley complete a risk assessment for all children or young people under the age of 16 who access the service. The risk assessment prompts practitioners to identify vulnerabilities, for example, drugs and alcohol use, age of partner, self-harm, teenage pregnancies, looked-after children and care leavers. However, the risk assessment does not indicate if CSE has been considered, nor does it direct practitioners to look at the completed vulnerability checklist risk assessment tool. In addition, the risk assessment is not routinely used for all under 18s unless vulnerabilities have been identified during the standard assessment process. This is a missed opportunity to identify additional vulnerabilities of this age group. This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health services.

3.17 The CASH service is not currently represented at the YPSE meetings so practitioners are not routinely notified when a young person is at risk of CSE. However, we were informed that, on those occasions when the CASH service have received notification of a young person at risk of CSE practitioners have proactively created a profile on the electronic patient records system indicating that the young person is known to the YPSE panel. This is good, as it immediately alerts other CASH practitioners who might see the person to consider additional vulnerabilities as part of the assessment process.

3.18 However, CASH records are currently not flagged to prompt practitioners to consider additional vulnerabilities such as child protection, child in need and looked after children cases. This is important for supporting clear and timely recognition of vulnerable children and young people and the accuracy of the assessment of their needs. This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health services.

3.19 Although CASH practitioners reported good understanding of their role and responsibility in making referrals to children's social care. There is a lack of follow-up where outcomes of referrals are not being shared with the service. CASH practitioners are not routinely invited to attend child protection conferences, core group or strategy meetings. This is a missed opportunity as CASH practitioners hold important information which can help contribute towards decision making. In one case that we sampled, we saw minutes from a child protection conference appropriately filed on to the health records; however, the CASH practitioner had not been invited to any safeguarding meetings, nor had they challenged why they had not been invited to attend despite the young person being known to the service. This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health services.

3.20 Community CASH practitioners do not have access to the hospital-based CASH health records, including GUM. Therefore, there is a risk that CASH practitioners will be seeing potentially vulnerable young people in the community without having complete access to all important sexual health related information about a young person. We were informed that the new electronic patient records system will enable practitioners working in any of the sexual health or contraception services to have access to all sexual health records, which will build on integrated working in order to improve services for young people. This will be a positive development.

3.21 From our case sampling it was evident that the 'think family' agenda is being implemented within the CASH service through questioning about parental responsibilities and recoding of information around children when identified. However, this could be strengthened further by including the children's full names and dates of birth and by also documenting where parents have refused to provide this information.

3.22 ED practitioners are required to complete referrals to children's social care when safeguarding concerns have been identified by the assessing practitioners. Initial concerns are reported by telephone, which is then followed-up in writing within the recommended timeframe. The referral forms prompt practitioners to provide as much information as possible, including the reason for making the referral. However, in cases sampled, referral forms did not contain an adequate amount of information that would support partners with decision making. This is a missed opportunity to better inform children's social care of individual risk to children and young people, including to siblings or children to whom adults have access. (**Recommendation 3.11**).

3.23 Referrals made to children's social care by ED practitioners are datixed, which is a system used by trusts to help improve patient safety. A copy of the referral for is also sent to the trust safeguarding children's team. The datix system is used by the named nurse to monitor and follow up outcomes of referrals. During our inspection it was acknowledged that referrals do not always articulate risk or concerns and despite being quality assured by the safeguarding team feedback is not provided to individual practitioners where referrals are considered to be lacking in detail. Such feedback would ensure that any learning is shared with professionals to ensure that future practice is improved. (**Recommendation 3.11**).

3.24 Adult mental health practitioners are fully engaged in child protection meetings. We also saw evidence of minutes from child protection conference being appropriately scanned onto service user records. This means that practitioners have readily available child protection action plans. This will support them to develop a more detailed service plan with adult patients in the context of their family circumstances.

3.25 The timeliness of notification to attend child protection conferences (often less than 24 hours) can cause difficulties for adult substance misuse practitioners due to pre-existing commitment in diaries; however, every effort is made to ensure that the service is represented and contributing to the decision making process. Adult substance misuse practitioners are required to routinely provide reports for child protection conferences on the formal report writing template, both when present and when unable to attend. However, in cases sampled we saw contributions being made verbally, which is not sufficient. We saw evidence of minutes from these meeting being filed on service user case records. This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.

3.26 The adult substance misuse service has implemented learnings from SCRs by developing briefing notes to identify professional development issues, in order to continue improving practice and, in particular, to safeguard children of adult service users.

**Good practice example:** Learning from SCRs has helped improve safeguarding practice in the adult substance misuse service. Following an incident of an adult service user's child ingesting their opioid medication the service has implemented a new protocol. Those service users who have children in their care are encouraged to opt for the medically assessed safer opioid substitution treatment. If service users choose not to change prescription then they will be on daily pick up to prevent risk of child ingestion. In addition, a leaflet is provided to parents and carers to highlight 'keeping children safe' and the dangers of methadone, alcohol and other drugs on children.

3.27 Practice has also improved as a result of the above learning by better supporting practitioners to ask sensitive questions to service users to further assess and analyse safeguarding risks. Within all records seen, practitioners identify if service users are parents or carers and the degree of responsibility for the children. Historically practitioners were not directed to record details of the child; however, the initial assessment template has been developed to include names, dates of birth and addresses. In addition, the service has developed a safeguarding children flowchart to ensure processes are followed, children continue to be identified and with parental capacity routinely assessed. However, more work needs to be done to ensure that adult substance misuse practitioners identify parenting or caring responsibilities in male service users. This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.

3.28 There are good flagging systems in place to alert adult substance misuse practitioners of any current or previous safeguarding concerns. Practitioners are able to identify any risks in relation to service user disengagement, which is supported by robust safeguarding service protocols. However, joint working with universal health partners could be strengthened. This would help ensure that risks relating to service users' substance misuse are jointly assessed, particularly in cases where there are safeguarding concerns that impact on the welfare of children and young people. This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.

3.29 All GP practices in Dudley have a named safeguarding lead GP that is available to the wider practice team for advice, support and guidance. In addition, all practice staff have access to additional safeguarding information, which includes a list of key contact details. This is easily accessible on the homepage of the electronic patient records system. This is good as it means that when the safeguarding lead GP is not available, information on how to safeguard vulnerable children, young people and their families is readily available.

3.30 In all GP records seen, flagging of electronic patient records of those children and young people subject to child protection or child in need plans, with a CAF in place or those looked after is routine practice. The alert immediately appears on the screen, when the child or young person's record is opened, which needs to be acknowledged before accessing the full record. This also includes flagging records of children and young people where there is known domestic abuse in the household. This means that GPs are in a position to easily identify vulnerable children and young people and consider the impact of their vulnerabilities on their health and wellbeing.

3.31 There is currently no oversight of the number of referrals made to children's social care from GP practices that we visited during our inspection. Therefore, we were unable to review and comment on the quality of referrals and whether they articulated risk or concerns. We were informed that there are currently no relevant input codes on the electronic patient records system to mark referrals; therefore, they are unable to audit the number of referrals being made. In one case sampled, the GP failed to recognise and refer a young person at risk of CSE to children's social care, despite documenting in the patient record that they were at risk of being groomed. This case was referred back to the CCG for a management review as this was a missed opportunity to safeguard a potentially vulnerable young person. (**Recommendation 2.5**).

3.32 The named GP acknowledges that not all GPs receive invitations to initial or review child protection conferences. There is an expectation that when notified and where possible GPs are expected to attend. However, where they are unable to attend due to practice commitments they are required to provide high quality reports to children's social care. The named GP has devised a conference report writing template, which was launched in November 2015. This prompts GPs to include as much information as possible in their conference reports. However, we saw variation in the quality of conference report, which were mainly descriptive and did not analyse any risk or concerns. In one, GP practice, the safeguarding lead GP was not aware of the new report writing template. (**Recommendation 2.6**).

3.33 GPs receive minutes from child protection meetings, which are being scanned onto patient records. This is important, as the information contained in conference minutes can support GPs to promote the welfare of children and young people registered at their practice, by having access to a comprehensive picture of the child or young person and their families' needs.

---

## 4. Looked after children

---

4.1 More work needs to be done to ensure that children looked after in Dudley receive timely initial health assessments (IHA), which are currently undertaken by an appropriately trained paediatrician. There is no formal cover when the paediatrician is on leave or absent from work and this has negatively impacted on the performance rates, along with timely notification from social care and service user refusals. We are aware that this issue was highlighted in the annual looked after children report of 2014-15 where only 55.5% of IHA were completed on time. A more recent report (January 2016) reported that 91% of IHAs were completed on time, which denotes a significantly improved picture. However, this has not been sustained and in March 2016, only 57% were completed; leading to an annual overall rate of 74%, which is well below levels required (**Recommendation 1.2**).

4.2 Dudley has adapted the former British Agency for Adoption and Fostering (BAAF) paperwork to prompt and ensure a more holistic health assessment for looked after children. However, IHAs seen provided only basic information, with some significant gaps. The child's ethnicity, language and faith were not routinely recorded. In addition, we saw case examples where there was limited exploration of parental health histories, including substance misuse and its impact on the unborn or new born baby. Maternal mental health and paternal health history were also not referenced. This lack of information can negatively impact of longer term planning for vulnerable children and young people that are in care. We could not be assured that these questions had been asked during the assessments and so a clear picture of the child's background could not be seen and any potential risk arising from parent's histories was adequately considered. The absence of this information can have a lifelong impact upon the child's journey throughout placement and into adulthood. (**Recommendation 1.3**).

4.3 It was acknowledged that capacity to gather information from the wider health economy in Dudley is limited, given the lack of administrative support for the paediatrician leading this work. Therefore, access to important information that can be made available from health professionals to make an accurate and meaningful assessment of the child or young person's health needs is often missing. For example, from the midwifery and mental health service, with limited information provided by GPs and health visitors. Gathering essential information as part of the child's care pathway is important and demonstrates compliance with the statutory guidance for looked after children. The current system means there is a risk that the resulting care plan would not meet the needs of the child. Having a complete personal and family history would considerably enhance the value of all health assessments and facilitate better awareness of health needs for children and young people. For example, when they are placed for adoption, cared for in foster placements or on return home. (**Recommendation 1.3**)

4.4 Priority has been given to ensure that review health assessments (RHAs) are undertaken in line with statutory guidance. We found that overall timescales for completion of RHAs is good in Dudley, with 90-95% completed on time. In Dudley, health visitors undertake all RHAs for children under 5 years old and school nurses for children over 5 and up to 16 years of age. The specialist looked-after children's nurse usually undertakes health assessments for those young people over 16, with priority given to young people placed out of area in neighbouring boroughs to maximise coverage. The looked after children's health team are generally informed about high risk children and young people living out of area, but recognise the need to strengthen their preventative focus on these young people. We heard that drop-in sessions in Dudley have been effective in enabling regular contact with older young people and care leavers. There is also a monthly mother and baby group for young women who were or are looked after children and undergoing assessment. This is positive practice as it provides an opportunity for both groups to receive regular help and advice, as well as peer-to-peer support.

4.5 The RHAs completed by health visitors were of a good standard; however, more work needs to be done to strengthen the assessment completed by school nurses. Health visitors were clearly reviewing health action plans, and identifying any unmet health needs, underpinned by a focus on attachment and emotional health which was clearly articulated through SMART action plans. There was also a strong focus on the child's voice in records that we reviewed. In addition, health visitors are asked to provide a further report for statutory looked after children reviews and the information provided was sufficient. In contrast, school nursing assessments reviewed were of a variable standard. Health action plans were not SMART and the voice of the child was not strong. Not obtaining and recording the voice of children and young people in the health assessment process means opportunity to engage them in the process and 'set the scene' for future interventions is limited. (**Recommendation 8.2**) This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.

4.6 The majority of IHAs are completed at Cross Street Health Centre and RHAs undertaken by school nurses completed in schools. We often hear from older young people that being given a choice of venue is important for them and that they do not like being subject to health assessments in school as this makes them feel different from their peers. (**Recommendation 1.4**).

4.7 The practice of recording consent for the health assessments of looked after children were found to be good in Dudley. Consent processes have been tightened to ensure that all necessary approvals for examination are in place. The specialist nurse will contact the social worker a few days before the assessment to remind them of the need to provide consent or for parents to be present as appropriate.

4.8 The looked after children team acknowledged shortfalls in practice for care leavers. Work needs to progress to ensure that all young people have a comprehensive health history when leaving care. The current arrangements only provide basic health information, in the form of a letter. For example, the focus is on the young person birth history and immunisation status. The specialist nurse for looked after children reported to have limited capacity to provide a more detailed picture of the young person's history. We heard that care leavers have been consulted about the content of their letters; however, this is an area for further review to ensure that young people have sufficient information about the things that matter most to them to inform their future needs. Young people should be provided with robust health information, which also incorporates parental health history, as it can help with their identity. In addition, it can be useful when they register for health services where questions around family history are often asked. (**Recommendation 1.5**).

4.9 The specialist nurse has a number of ideas about ways in which the looked after children health offer could be strengthened; however, we heard that due to capacity issues it has been a challenge to progress them. The looked after children health team have good engagement with the children in care (CiC), corporate parenting and CSE meetings. In addition, there is good level of partnership working between looked after children health team, frontline social workers and personal advisers. The independent reviewing officers receive a copy of the child's health care plan, to inform them regarding the child's health at the Statutory LAC review. The minutes of the review are appropriately shared with the relevant health professionals.

4.10 The designated nurse for looked after children is undertaking work through the virtual head and Healthwatch to identify a cohort of looked after children to 'test' a jointly agreed questionnaire. The questionnaire will be a self-check happiness and wellbeing test. This demonstrates good multi service development which is focusing on the emotional wellbeing of children looked after in Dudley.



4.11 Due to a number of health providers in Dudley, information flows between all relevant partners is a challenge and a barrier to the delivery of holistic joint support for looked after children. However, active steps have been taken by the designated nurse for looked after children to better understand the relationship with services offered to looked after children, as well as increase knowledge around foster care support, by meeting with the lead for CAMHS. In addition, the looked after children consultation service provided by CAMHS offers a real opportunity for social workers, teachers, and foster carers to reflect and better understand the needs and behaviours of young people. This positively includes children placed out of area and kinship carers.

4.12 The focus on children's emotional and mental health within the looked after children health review process is limited. Foster carers or the young person are required to complete strengths and difficulties (SDQ) questionnaire, which is forwarded to the local authority, looked after children psychologist for scoring. However, the looked after children health team are not informed about SDQ scores, which impacts on their identification and recognition of risk and means the health assessments and care plans may be missing relevant information. This is also a missed opportunity to identify need in a review and to monitor a child's emotional health over the period of time they are looked after. (**Recommendation 1.6**).

4.13 GP focus on looked after children is evolving; however, we found that it was not yet sufficiently embedded. Although part C of the BAAF health assessment form is routinely shared with GPs, there is recognition of the need to improve awareness and understanding of GPs responsibilities for looked after children. Children looked after in Dudley are not benefiting from routine input by their GP into their IHA or RHA. This impacts on looked after children, as health plans may not be informed by all pertinent health information. (**Recommendation 2.7**).

4.14 Midwives, health visitors and FNP nurses paid good attention to the vulnerabilities of looked after children and young people, with sensitive recognition of the needs of those who are looked after or care leavers. Good support to foster carers is provided by health visitors, enabling them to better understand the specific health needs of looked after children and young babies. In cases sampled, we saw effective recording of the child's transition to foster cares and of new routines and relationships. This is important as it can help empower foster carers to develop strong, trusting relationships with children and young people looked after, thereby improving their health outcomes. All looked after children who are pregnant are routinely discussed in the unborn baby network meeting facilitated by the midwifery service. In addition, midwifery cases seen denoted good joint working with the specialist nurse in the looked after children team and the FNP service.

**Case example:** A young person in foster care was enrolled onto the FNP programme at the age of 17, when she was 20 weeks pregnant expecting twins. She has a previous history of anxiety and depression, including an episode of self-harming behaviour. The FNP nurse has developed a trusting and therapeutic relationship with the young person and offered her support across a wide variety of needs including; smoking cessation, integration into the local community and education, parenting and housing. The case demonstrated good joint working between the midwife and FNP service in planning the safe delivery of the babies.

**Outcomes:** The support offered to this young person has enabled her to continue gaining confidence in order for her to meet the needs of her twins, who are almost one year old. She has now secured her own tenancy and continues to engage with the FNP.

---

## Management

---

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

---

### 5.1 Leadership and management

---

5.1.1 The absence of strong strategic leadership in looked after children is hindering effective progress of the looked after children agenda in Dudley. Resourcing of and the contractual agreements for the designated nurse and designated doctor for looked after children do not meet the standards outlined in the intercollegiate guidance, 2015. The designated doctor and designated nurse for looked after children sit in the provider organisations; therefore, it does not allow for the strategic role to be fully developed.

5.1.2 The designated nurse for looked after children functions primarily at an operational level, with the majority of her work focused on the delivery of and quality assurance of RHA activity. This has been highlighted as a risk on the risk register of the provider organisation and an area for development since 2014. The designated nurse for looked after children reported challenges of not fully understanding and subsequently influencing commissioning arrangements with the current setup, which is taking a lengthy time to resolve. The post holder recognises that there may be services that could be better tailored to meet looked after children's needs but is not fully aware of how these are commissioned, due to being part of the provider organisation. The lack of resolution is a weakness and does not assist driving forward improved outcomes for looked after children. There still needs to be prompt resolution to ensure that both designated posts move to the CCG from the respective provider sites. This will help improve outcomes for looked after children in Dudley. (**Recommendation 1.7**).

5.1.3 Clinical capacity of the paediatrician who undertakes IHAs and adoption medicals is disjointed. Capacity gaps remain which have contributed to poor performance in ensuring IHAs are undertaken in a timely manner. (**Recommendation 7.2**).

5.1.4 Recognition of the needs of the population of looked after children and the health inequalities they experience are not sufficiently developed in Dudley. The specialist nurse for looked after children advised us that the looked after children health team does not hold a spreadsheet that provides an overview of the unique identities and needs of children who are looked after. They therefore do not have a clear picture of ethnicity, disabilities or specific vulnerabilities. For example, young people living in or out of the area misusing substances or at risk of CSE. In addition, young people placed out of area, and those within the age range of 16 to 18 years, would benefit from closer scrutiny to ensure they are accessing the range of universal and specialist health services they need. This has been identified as an area to strengthen. (**Recommendation 1.8**).

5.1.5 The looked after children service in Dudley does not have an annual work plan outlining priorities for delivery over the next three, six or 12 months. There is currently no framework in place inclusive of the relevant local providers to progress this. The annual plan 2014 to 2015 provided a basic overview of performance against key performance indicators. The focus on the impact of health assessment and care planning activity and outcomes for children and young people needs strengthening. This is important as a strong service work plan is fundamental for monitoring progress against identified development areas and ensuring that looked after children get the best care and support, as well as improved life outcomes. (**Recommendation 1.9**).

5.1.6 There is more work to do to ensure that the voice of children and young people looked after is embedded in shaping the looked after children service in Dudley. Although feedback is encouraged, return rates of feedback forms following assessments are still relatively low, as the process only started in April 2016. Participation and engagement with looked after children are important at a number of levels. For example, they have insight into their needs and the right to influence their care, as well as services on offer to them. (**Recommendation 1.10**).

5.1.7 The midwifery service in Dudley, provide good support for vulnerable women. This includes a safeguarding lead, the named midwife, who primarily supports the development of midwives safeguarding practice and who has a special interest in substance misuse. In addition, there is close working alongside another midwife for vulnerable women whose role includes the management of risk in relation to mental health, domestic abuse, travelling families, and teenage pregnancies. The named and vulnerable women's midwives have clear accountabilities, and although a small team, they work well together to ensure continuity of support to frontline staff in the hospital and community.

5.1.8 Despite challenges on local capacity in responding to pregnant women with mental health needs whilst they await admission to a specialist mother and baby unit, cases seen were appropriately managed through positive joint working between the midwifery and adult mental health service. However, there remain gaps in the local offer in relation to perinatal mental health services. Further review of capacity is required given gaps in provision for pregnant women with dual diagnosis and young mothers-to-be with mental health issues, particularly as Dudley does not yet have in place relevant roles and levels of expertise as outlined in the DH guidance. (**Recommendation 4.1**).

5.1.9 There is active management of capacity issues and vacancies in the midwifery service at Russells Hall Hospital and on the whole they are compliant with national workforce planning tools. In contrast, community midwives' cases are slightly higher than the recommended levels; however, their work is appropriately supplemented by support from the 'Healthy Pregnancy Support Service', which is a team of band four health care assistants. Midwifery staffing levels have been reviewed and are compliant with safer staffing requirements.

5.1.10 The dedicated children's ED area is very much oriented toward younger children and not older young people. Not all children and young people visiting the ED are cared for by appropriately trained sick children's nurses. We were informed that historically there has been a high turnover of paediatric trained staff in ED and concerns were highlighted about retaining paediatric trained nurses. Following a scoping exercise, a decision was made to open the dedicated children's ED during the department's busiest time, which is reported to be during the hours of 11am-midnight. However, we saw children and young people during these times waiting in the main ED waiting area for their assessment and treatment, which is not a suitable environment.

5.1.11 In Dudley, there is strong team leadership and morale underpinning the work of health visitors and school nurses, with full implementation of the HCP. In health visiting, there was good recognition of the need to continuously improve local performance, with senior managers across providers working closely in particular to strengthen the coverage of antenatal visits.

5.1.12 Health visitor caseload sizes are around 320 per whole time equivalent, which is just above the minimum floor standard of 300 as outlined by the Institute of Health Visiting guidance (IHV, 2015). However, no capacity concerns were raised at the time of our inspection. Due to pockets of deprivation in Dudley, child protection cases are shared out equally across the health visiting team.

5.1.13 A number of school nurses have recently been employed in Dudley, and as a result there is a band six school nurse in every secondary school. This promotes accessibility and visibility for children and young people.

5.1.14 School nurses reported good awareness of the formal escalation policy in resolving professional's disagreements with social care. However, we found evidence of the escalation process not being robustly implemented, as concerns raised were not responded to and no further action was taken, either by the school nurse or the social worker.

5.1.15 The CCG and its health partners recognised the shortfalls in local safeguarding arrangements highlighted in the previous CQC safeguarding and looked after children inspection report, 2012. We were able to witness on this review a 'think family' approach in mental health and the substance misuse service with improved recognition of the complexity of safeguarding children. Escalation processes had been strengthened and were being raised to help increase awareness of risk and to challenge cases where drift had been identified.

5.1.16 CAMHS practitioners openly commented on positive morale, team working and leadership within the trust, with a strong child centred focus and vigilance to safeguarding risks. We found that this was integral to and positively impacted on the clinical work of CAMHS practitioners, in particular to managing risk and improving outcomes for children and young people with complex emotional, mental health and behavioural needs.

5.1.17 There needs to be a review of the work undertaken by the local authority funded psychology service and that delivered by CAMHS as currently there is a lack of joint working and risk of duplication, as both professionals are doing SDQ scores. The results are not being shared between professionals, and changes in scores need to be more proactively managed and shared with other relevant providers. We were informed that CAMHS have been working with the local authority psychology team over the last 12 months and are currently waiting for the local authority to sign off the agreed pathway for looked after children into the CAMHS service.

5.1.18 Dudley and Walsall Mental Health Trust have strengthened their safeguarding capacity by appointing two additional safeguarding lead practitioners. This enables the trust to have strong oversight of safeguarding children and adult activity and track progress in addressing concerns, as well as providing additional support to frontline staff as required.

5.1.19 We found evidence of good joint working arrangements between the adult mental health team and the adult substance misuse service in co-delivering care to adults with a dual mental health diagnosis. Case records seen denoted good communication and information sharing between the two organisations. In addition, there is good evidence of management oversight of cases when decisions are being made to close cases following a package of care.

5.1.20 The adult substance misuse service has developed a case management workbook, which is being embedded into practice. This will be a useful toolkit for practitioners to develop and strengthen continuity of standards within their practice. For example, ensuring that consent is routinely discussed and information sharing if risks are identified in respect of children. In addition, we saw evidence of appropriate professional challenge by senior managers if practitioners fail to identify risk and where safeguarding standards are not being met.

5.1.21 The named GP for Dudley has worked closely with the CCG and in particular the designated nurse for safeguarding children to set up twice yearly children's safeguarding workshops for all safeguarding lead GPs. The workshops have included scenario based learning, as well as updates from SCR and presentations by other professionals including health visitors and children's social care. This is an important development as it means that all lead GPs have the opportunity to liaise with their peers, and keep themselves up to date with changing practice, which can then be cascaded to GP colleagues from within their individual teams. The workshops have been evaluated well by GPs who have attended.

5.1.22 The named GP informed us that not all GPs in Dudley hold regular multidisciplinary safeguarding liaison meetings with health visitors, school nurses or midwives. This is a missed opportunity for partnership working and to improve outcomes for vulnerable children and young people. This has been recognised as a gap by the named GP and CCG. Therefore, there is a GP communication task and finish group that is currently looking at how working relationships with community practitioners can be improved. (**Recommendation 5.1**).

5.1.23 The MASH health nurse does not have an integrated IT system whereby they can access both children's social care and health data bases. This affects the timeliness and efficiency of accessing and recording information.

---

## 5.2 Governance

---

5.2.1 The designated safeguarding children's nurse is an active member of the safeguarding children board in Dudley and associated sub-groups including the quality safety committee, where safeguarding is a standard agenda item. The CCG seeks assurance from clinical quality review meetings, which is currently attended by the children, young people and families' commissioners and key safeguarding lead representatives from health providers.

5.2.2 The CCG acknowledge the need to strengthen the looked after children service offer in Dudley. There remains uncertainty about designated and operational roles and accountabilities; with no formal partnership agreement between the respective provider organisations for looked after children. Therefore, the role interface, joint working and information sharing arrangements between designated professionals are not adequately developed. Designated professionals can assist service planning and advise CCGs in fulfilling their responsibility as commissioners of services to improve the health of looked after children in accordance with the intercollegiate guidance. Therefore, the current arrangements are not sufficient in meeting the needs of the service, as identified during our inspection and therefore, this requires urgent attention from the CCG. (**Recommendation 1.7**).

5.2.3 The paediatrician undertaking the IHA does not benefit from having an agreed job description, work plan or formal performance management or peer oversight of his work. Whilst the designated nurse for looked after children reviews all health assessments and provides a monthly safeguarding dashboard report, quarterly reports of activity and delivers the annual report, there is no formal governance in place in relation to the community paediatrician's role. (**Recommendation 1.11**).

5.2.4 We found evidence of good board to floor governance in relation to the management of safeguarding activity within the midwifery service. The safeguarding dashboard reports to the trust board and clearly flags any trends and areas of shared practice that reflect wider partnership working. For example, numbers of late bookers, young mothers, maternal mental health and substance misuse. This framework is also in place for children and adults within the Trust.

5.2.5 In midwifery, appropriate action is being taken to address gaps in local arrangements in relation to learning from a recent SCR. In particular, the trust is seeking to ensure there are appropriate flags on the record keeping systems for unborn babies.

5.2.6 The Dudley safeguarding children board, in conjunction with the designated nurse for safeguarding children have started to address weaknesses and inconsistencies identified in referral pathways for managing concerns about unborn babies. In some cases seen, acceptance of the multiagency referral form was inappropriately delayed due to a blanket approach of more than 20 weeks before children's social care would undertake an assessment. This practice does not recognise the complexity and risks of individual circumstances. This has led to some vulnerable children and their babies not sufficiently being protected through robust pre-birth planning. This practice does not also effectively support the early help offer for families with lower level risks. (**Recommendation 3.12**).

5.2.7 In health visiting and school nursing, we found that operational governance arrangements and processes required further development. It was reported that child protection cases, reports or referrals to children's social care are reviewed in the form of audits undertaken by the safeguarding team. However, we could not be assured at the time of our inspection that the system currently in place was robust enough in terms of providing quality assurance measures in order to improve practice. We were informed that from July 2016, a datix system will be used to highlight all referrals to children's social care and any cases that have required escalation. This will be a positive development as it will provide better management oversight of safeguarding practice. However, there is no formal action plan to support the development of safeguarding practice. This has been recognised as a gap and we heard of a recent audit of safeguarding notes that started in April 2016. The audit identified lack of analysis and voice of the child in health visiting records, which was also evidenced during our inspection. However, in contrast we found the voice of the child clearly evident within FNP records that we reviewed. In order to share learning from the audit and to improve practice, a training session has been planned for practitioners. (**Recommendation 8.2**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing service.

5.2.8 Health visiting, school nursing and adult substance misuse records reviewed were more descriptive rather than analytical, and they did not always articulate concerns or risks with sufficient clarity. Where action plans were being identified they were not always SMART. This is important to ensure continuity of health care and identified health needs of children and young people are met promptly. (**Recommendation 8.3**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting, school nursing and adult substance misuse service.

5.2.9 Record keeping systems in health visiting and school nursing requires strengthening in Dudley. Although safeguarding records, for example child protection plans, looked after children, child in need and CAF cases are kept in separate filing cabinets there is no identification on the outside or the front sheet of the paper records to alert practitioners of any safeguarding or historical concerns. The intended move to electronic recording will help to facilitate the application of a robust case recording model and of a stronger approach to recording practice and records management. (**Recommendation 8.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing service.



5.2.10 Within the CASH service there is no internal safeguarding auditing system in place. Risk assessments and referrals to other agencies are not quality assured. There is an overreliance on multiagency LSCB lead audits and lessons learnt from SCRs to develop practice learning. The quality of referrals to children's social care was seen and they did not contain robust information about the concerns being highlighted and the impact on health outcomes. Lead safeguarding nurses within the CASH service do not provide quality assurance and oversight of case records and referrals. In addition, there is no current data base to track cases that have been referred to children's social care. This would help identify outcomes, inform action plans to be monitored, reviewed and implemented. This would also provide a measure for dispute resolution or support initiation of escalation processes. **(Recommendation 3.13)** This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health service.

5.2.11 CASH and CAMHS are currently using both paper and electronic recording systems. This is a risk as it can significantly impact on timely information sharing and effective communication within and between the range of local health services and partner agencies. Providers were at various stages in their transition to electronic systems. A recent CQC report, identified gaps in the dual use of paper and electronic records within CAMHS and adult mental health; these include challenges in ensuring shared access hospital based and community health records and ensuring relevant information is inputted on paper and electronic systems. As a result an information governance strategy is being developed to address this issue. This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health service.

5.2.12 During our review of adult mental health records, we found that electronic records provided flags for some areas of vulnerability. These included safeguarding children and adults and domestic abuse, as well those service users who were pregnant or known to be violent. However, the service did not flag those children and young people looked after which is a key concern in the care of young people aged 16 to 18 who are routinely being managed in adult mental health services. **(Recommendation 4.2).**

5.2.13 There is strong governance and oversight of safeguarding and patient safety with a clear work plan and reporting systems within the Dudley and Walsall Mental Health Trust. A range of audits are in place to support assurance that the right standards of care are being delivered. These include care programme approach audits, which incorporate focus on alerts and risk management, records, spot checks by managers, Section 11 (Children Act 2004) audit issues, and multi-agency audits.

5.2.14 In Dudley, a good range of integrated support is available from the adult substance misuse service. For example, psychosocial support, group work, one-to-ones, clinical interventions, health assessments and mental health support. The adult substance misuse team are continuing to develop their joint working and pathways with partnership agencies. In one case reviewed, we saw evidence of a robust pathway between the adult substance misuse team and the specialist midwife service. In contrast, we were informed that the mental health pathway has recently been signed off after two years in development. Links with the health visiting team are being established but it was reported by the senior management team that more work is required to fully embed information sharing.

5.2.15 In ED, there are good arrangements for reviewing all records of those patients who leave the department without treatment, or do not return for clinic appointments. We were informed that ED is included in the annual safeguarding children audit (last completed March 2015). The Trust's external auditors have also recently completed an audit of the safeguarding training policy (January 2016). The annual safeguarding children audit is now due, which will help ensure that ED practitioners are compliant with guidance, for example appropriately referring to children's social care and completing paediatric liaison forms. We were informed that the PLN completes a monthly audit and records information on the number of children and young people attending the ED following an overdose, mental health crisis, and substance and alcohol misuse.

---

## 5.3 Training and supervision

---

5.3.1 Access to safeguarding training ensures continuous professional development and that practice has a strong evidence base. Most health practitioners in Dudley undertake level three safeguarding training commensurate with their role and responsibilities. However, for the most part, this is training provided by the individual provider and while multidisciplinary, lacks the multiagency component that would make it fully compliant with the intercollegiate guidance. All health professionals are encouraged to access multi-agency training, which is provided by the local safeguarding children's board (LSCB). This has included CSE, FGM, domestic abuse and neglect. However, it was highlighted during our inspection that a number of LSCB training sessions have been cancelled, therefore making it challenging for health professionals to access multiagency training. **(Recommendation 7.3).**

5.3.2 Named midwives are actively involved in the delivery of face-to-face level three safeguarding training, which is available for practitioners to access four times a year. The intercollegiate document 2014, clearly states that midwives are specifically required to access multidisciplinary, interagency level three training at specialist level (minimum of 12-16 hours over a three year period). Training to the appropriate level will help ensure that all practitioners are competent at assessing, planning, intervening and evaluating the needs of a new born and parenting capacity where there are safeguarding or child protection concerns.

5.3.3 Newly qualified midwives were encouraged to shadow the named midwife or the vulnerable women's midwife at key child protection meetings. In addition, the preceptorship package for newly qualified midwives includes a clear focus on safeguarding at induction and as part of their continuing professional development programme; with mentoring support from specialist midwives as part of the local offer. This will effectively help support newly qualified midwives at an early stage of their professional career. In addition, all midwives who have had extended leave from practice were included in a safeguarding induction process. This will further aid the learning and development of midwives and prioritise the safeguarding element of their role.

5.3.4 Whilst the named safeguarding midwives benefited from regular safeguarding supervision from the designated nurse, the practice of frontline midwives is not benefiting from regular in-depth one-to-one supervision. There is an over reliance on *ad hoc* advice and support or debriefings following incidents. This level of supervision for midwives is not sufficient to best support practitioners in their day-to-day practice. Frontline midwives would benefit from a regular and structured process to enable them to continuously improve their safeguarding practice in the management of complex cases. In addition, the current arrangement could restrict supervisory oversight and the opportunity for a degree of professional challenge, particularly in vulnerable cases that are identified and for those women where increased support or intervention is necessary. It would further reduce the likelihood of risk being overlooked and would best support practitioners working with highly vulnerable women and their unborn babies. (**Recommendation 10.1**).

5.3.5 All practitioners need to ensure they have accessed safeguarding level three training so they are up to date with changes in guidelines and safeguarding practice and procedures. Black Country Partnership Foundation Trust (BCPFT) are clear that health visitors should be trained to level three and that this should include a multiagency component. Training data reviewed for key performance indicators during 2015 to 2016, indicated that 96% of health visitors have completed their safeguarding mandatory training. The health visiting manager has good oversight of the safeguarding training needs of the team.

5.3.6 School nurses have access to in-house level three safeguarding training, with three yearly updates. Compliance with safeguarding level three training is monitored by service managers via the electronic staff record system. This means that the trust has systems in place to ensure that all practitioners are accessing safeguarding training within the recommended timeframe. School nurses have also had access to CSE training, which consisted of a two hours briefing session.

5.3.7 In both health visiting and school nursing, practitioners have access to a one-off safeguarding supervision session when a child becomes subject to a child protection plan, which is provided by the safeguarding children's team. The supervision of the child protection case is then referred back to the relevant service where three monthly group supervision is on offer. In addition, *ad hoc* one-to-one supervision as identified and requested by practitioners is also available. Although practitioners can access advice as and when required it is currently the duty of the practitioner to decide which cases to take to supervision, with no robust management oversight and review to ensure children and young people at risk are safeguarded well. However, we were informed that if a child has been subject to a child protection plan for over one year, it is referred back to the safeguarding team for supervision. During our inspection we found that the paper template used to record safeguarding supervision does not meet the needs of health visitors and school nurses and we saw evidence that outcomes following a safeguarding supervision session are not analytical or SMART. More detailed and outcome focused plans need to be documented on the clients' records in order to review progress and inform ongoing practice. The supervision records are kept separate, which is a risk as practitioners and managers will not have immediate access to actions following supervision, which should be informing and steering day-to-day practice. A lack of robust supervision processes was identified in a local SCR in 2013; however, we could not be assured that learning from this SCR in relation to safeguarding supervision have been implemented into practice. (**Recommendation 10.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing service.

5.3.8 BCPFT have implemented a system, whereby the named nurses from the safeguarding team undertake an audit of every new child protection plan during the initial supervision session, this ensures that the audit can be shared with social care leads on a monthly bases.

5.3.9 SCHAT recognise that the level of safeguarding supervision currently provided to school nurses by BCPFT is not adequate. Although named nurses from both trusts meet regularly to discuss any safeguarding or practitioner concerns, more work needs to be done to ensure there are robust safeguarding supervision processes in place. We heard of plans to strengthen the safeguarding supervision offer for school nurses, whereby the named nurses at SCHAT will provide school nurses with one-to-one safeguarding supervision every six months. In addition, the supervision will incorporate a review of child protection reports and referrals. We were informed that BCPFT supervision policy includes SCHAT, as there is a memorandum of understanding in place. However, it is not clear if there will be a joint policy and quality assurance system in place, which may result in further confusion of safeguarding supervision within the school nursing team and variations in practice.

5.3.10 The looked after children nurses provide training to frontline health visitors and school nurses to enable them to understand their professional accountabilities and raise awareness about the standards of practice required when undertaking health assessments of looked after children. Recent learning has been to strengthen community practitioners focus on the voice of the child and to ensure all relevant health checks are in place and up-to-date. In addition, all safeguarding training levels two and three provided within the BCPFT include reference to the vulnerability of looked after children.

5.3.11 The CCG designated nurse for safeguarding children is appropriately trained to level five and provides safeguarding supervision to all provider safeguarding nurses, including the designated nurse for looked after children. In addition, the designated nurse for looked after children has joined a peer review group for looked after children nurses, which is reported to be a supportive learning environment. The opportunity for sharing good practice and discussing challenges could assist in improving services.

5.3.12 The designated nurse for looked after children and specialist nurse have weekly one-to-one meetings every six weeks with the head of safeguarding. This is a good opportunity to provide peer supervision.

5.3.13 Community CASH services and GUM practitioners are fully compliant with level three safeguarding training. However, within Brook only the nurse manager and service manager are trained at level three. This is not sufficient, as all practitioners who have contact with children and young people should have access to multiagency safeguarding training, which can help ensure that practitioners are better informed and able to tackle a range of risk factors in vulnerable young people. This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health service.

5.3.14 Formal safeguarding supervision arrangements are not in place for CASH and GUM practitioners. We were informed that this is due to practitioners not being safeguarding care holders. There is an opportunity for practitioners to access *ad hoc* safeguarding supervision; however, there is no record of discussions held on service users' health records. Therefore, there is no process to track this or audit actions from it. Within the community CASH service, safeguarding supervision is provided by the Respect Yourself team and as a result recorded on the local authority system. Brook has a new policy for supervision and this involves three monthly group and three monthly one-to-one supervision. In addition, it is reported that there is the opportunity for *ad hoc* supervision; however, they too do not record the outcome of safeguarding discussions on service user records. Safeguarding discussions should be documented in health records to ensure that practitioners keep a focus on vulnerable young people and to avoid drift. Supervision records should also provide clarity of actions and professional accountability for safeguarding vulnerable children and young people. (**Recommendation 10.1**) This issue has been drawn to the attention of Public Health, as the commissioners of the contraception and sexual health service.

5.3.15 Dudley and Walsall Mental Health Partnership NHS Trust clearly recognise their responsibilities for promoting a diverse, fair, personal and inclusive NHS. They have implemented a range of cultural competency training for staff, which includes lesbian, gay, bisexual and transgender, and migration and cultural awareness training. In addition, the trust has given high priority and provided training and awareness raising sessions for health professionals so that they can better understand their role and accountability for delivering the PREVENT programme, which is part of a counter-terrorism strategy. A number of briefing and updates sessions have been on offer to practitioners so that they remain up-to-date with more contemporaneous safeguarding issues, such as FGM and forced marriages.

5.3.16 Within CAMHS, although there is evidence of a high level of training coverage in relation to level three safeguarding, figures reported indicate the need to further build awareness and increase the skills of those practitioners who are not directly involved in the care of children, but who still have contact with children. Safeguarding supervision arrangements are well embedded in CAMHS and are supporting a high standard of safeguarding practice.

5.3.17 Health professionals working on the paediatric ward at Russells Hall Hospital are required to attend Conflict Resolution, which is specific to children and young people as part of the mandatory training programme. However, they have not attended any formal training on working with children and young people with additional emotional health need; for example, self-harm, overdose or general mental health needs. This is important given that CAMHS patients are frequently staying for lengthy periods of time on the ward whilst a tier four urgent care bed is located for them. We were informed that where possible an appropriately trained bank mental health practitioner will be arranged to provide one-to-one support and additional observations if identified. However, where this is not possible additional support will be provided by the existing nursing establishment. (**Recommendation 6.3**).

5.3.18 More work needs to be done to ensure that all ED practitioners have accessed level three safeguarding training, as compliance is currently very low at 66%. The safeguarding training is delivered in-house and largely as a single agency. We were informed that this is being monitored by the trust, as well as the CCG. In addition, ED practitioners have not accessed any formal CSE specialist training, although it was reported to be delivered as part of the level three training. Access to specialist training is important for a number of reasons, but mainly as ED practitioners may be able to identify signs of sexual and physical abuse or signs of violence when a child or young person presents with an injury. Having appropriate training can support ED practitioners to identify these vulnerable young people and therefore make timely on-going referrals to safeguarding children and young people. (**Recommendation 3.14**).

5.3.19 ED practitioners do not have access to formal safeguarding supervision. However, they have readily available access to the trust safeguarding children team, and can request one-to-one *ad-hoc* supervision if identified as an individual need. We heard that the trust recognise this as an area for development and in response have scheduled bi-monthly safeguarding forums available to all practitioners. This is an opportunity to discuss vulnerable cases. Although this is good, there is an overreliance on *ad-hoc* support and guidance from the safeguarding team. (**Recommendation 10.1**).

5.3.20 All adult mental health practitioners have been trained to level three against the intercollegiate guidance, with the named and head of safeguarding trained to level four. In addition, the trust has provided input into the safeguarding training for midwives to strengthen awareness of individual and joint responsibilities for maternal mental health. The safeguarding children and adult training on offer also includes a strong 'think family' focus. This is important within adult facing services, as practitioners will be encouraged to consider the parent, child and the family as a whole when assessing the needs of and planning care packaged for families and parents with a mental health problem.

5.3.21 The adult mental health service has clear system in place to cascade safeguarding supervision through the named and lead safeguarding professionals to frontline practitioners. The trust has taken forward a recommendation from the recent CQC regulatory inspection to ensure there is a central process for logging supervision. This provides the trust with assurance that all practitioners are receiving the level of support and oversight of practice that they need when working with vulnerable families.

5.3.22 There is currently no management oversight of safeguarding level three training in the adult substance misuse team; therefore, we could not be assured that all practitioners have accessed the appropriate training required for their role and responsibilities. However, safeguarding supervision arrangements are good, with practitioners having access to monthly group supervision. Practitioners are required to identify a case that they wish to discuss during the supervision session, which is reviewed by the safeguarding supervisor prior to the session. Actions and outcomes of discussion are recorded on a spread sheet and sent to team leaders to maintain management oversight of the cases. We also saw evidence of safeguarding discussion being recorded on service users' health records. In addition to scheduled safeguarding supervision session, adult substance misuse practitioners also have the opportunity to discuss safeguarding cases at weekly team meetings.



5.3.23 Although there is an expectation that all GPs in Dudley access yearly online level three safeguarding training, provided by an established online learning organisation, not all GPs that we visited are compliant. In one GP practice that we visited, only the safeguarding lead GP had accessed level three training, and there was no awareness that GP partners or colleagues should also be trained to this level. However, we were informed that GPs have received the CCG competency framework which explains the level of safeguarding training required by practitioners. Additional to the e-learning available online, GPs are also encouraged to attend face-to-face training provided by the LSCB. However, this is not a mandatory requirement. GPs may find it advantageous to attend 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 2.8**).

5.3.24 The safeguarding lead GP that we visited during our inspection had accessed specialist training in relation to CSE and FGM through the safeguarding workshops delivered jointly by the named GP and designated nurse for safeguarding children. However, we found variation in how this learning is cascaded to colleagues. Shared learning would enhance all practice staff's ability to identify and highlight any potential concerns to a senior member. We were informed that the CSE risk assessment tool has been disseminated to all GPs with a briefing in 2015. One GP that we spoke to reported awareness of the CSE risk assessment tool and FGM reporting system; however, practitioners displayed poor knowledge of CSE and FGM. (**Recommendation 2.1**).

5.3.25 A weekly newsletter is disseminated to all GPs in Dudley. The newsletter gives an overview of safeguarding children activity, including good practice and any learning arising from significant events or SCR. This is good, as it gives GPs the opportunity to keep up-to-date with changing practice.

---

## Recommendations

---

1. **Dudley CCG in partnership with Dudley Group NHS Foundation Trust and Black Country partnership Foundation Trust should:**
  - 1.1 Develop a robust handover system between midwives and health visitors, so that all relevant information is shared and recorded in order to ensure continuity of care.
  - 1.2 Ensure that all children in care have timely and high quality, holistic assessments and reviews of their physical, emotional and mental health needs informed by SMART health plans which reflect the child's voice.
  - 1.3 Ensure there are robust systems in place to gather family medical histories and that they are recorded and transferred onto the health assessment documentation as part of initial health assessments.
  - 1.4 Ensure that children and young people in care are given a choice about where they would like their health assessment done. This will help facilitate engagement with the service.
  - 1.5 Develop robust processes to ensure that all young people leaving care routinely have access to their health histories or a summary of them.
  - 1.6 Implement a robust system to enable SDQ scores to be shared with practitioners undertaken IHA and RHA,
  - 1.7 Ensure that actions are urgently progressed to ensure the focus of designated posts for looked after children complies with the intercollegiate guidelines.
  - 1.8 Implement robust systems to ensure that the looked after children health team are aware of the needs of the looked after children population in Dudley.
  - 1.9 Ensure there is a current looked after children work plan, which will better support the looked after children health team to monitor progress against key development areas.
  - 1.10 Ensure the voice of the child is developed in initial and review health assessments and children and young people are given the opportunity to actively engage in the health assessment process.
  - 1.11 Implement a quality assurance process to ensure that all looked after children work is of a high standard.

## **2. NHS England in partnership with Dudley CCG should:**

- 2.1 Ensure that GPs have access to a young person specific sexual health and contraception template and are aware of and competent in the use of the CSE risk assessment tool so that early signs of children and young people at risk of CSE can be easily identified.
- 2.2 Ensure that all GPs document the full name and relationship of the adult accompanying the child or young person to their appointment on the electronic patient records. This will need to be audited to monitor compliance.
- 2.3 Formalise the arrangements to ensure that GPs routinely share health information with the MASH.
- 2.4 Ensure that GPs keep up-to-date records following multi-agency discussions.
- 2.5 Implement new codes on the patient electronic record to help develop more intelligent and accurate health profile of children and young people in Dudley.
- 2.6 Ensure that all GPs are aware of the new conference report writing template, which will better support GPs to analyse any concerns. This will need to be audited to monitor compliance.
- 2.7 Ensure that GPs have a good understanding of their role and responsibilities in the provision of good health care for looked-after children and that they have the opportunity to contribute routinely to initial and review health assessments.
- 2.8 Ensure that all primary care practitioners have access to level three safeguarding training in accordance with the intercollegiate guidance on roles and competences issued by the Royal College of Paediatrics and Child Health.

## **3. Dudley CCG in partnership with Dudley Group NHS Foundation Trust should:**

- 3.1 Ensure that ED is represented at the local YPSE panel, so that local intelligence can be gathered.
- 3.2 Formalise the arrangements to ensure that ED practitioners routinely assess the vulnerabilities of older young people.
- 3.3 Implement a robust protocol to ensure that all under one year old non-ambulant babies attending the ED with injuries, for example, head injury, burns and fractures are reviewed by an appropriately experienced, trained and skilled doctor.

- 3.4 Ensure the voice of the child is reflected in ED records.
  - 3.5 Ensure that there is sufficient paediatric liaison capacity to support best safeguarding risk assessment and practice in the ED, which also includes the adult ED. This will help ensure that potentially vulnerable children and young people are appropriately followed-up by community services.
  - 3.6 Ensure that GPs and community practitioners receive detailed discharge summaries of children and young people discharged from ED. Implement a system to quality assure the level of detail included so that community teams are better informed.
  - 3.7 Formalise arrangements to ensure that all ED practitioners refer young people who present in ED with alcohol and substance misuse issues to appropriate support services.
  - 3.8 Ensure that all young people admitted to wards at the Russells Hall Hospital for medical treatment and whilst waiting for a formal CAMHS assessment are formally risk assessed to ensure both their safety and that of others on the ward.
  - 3.9 Ensure that adult ED documentation sets out appropriate prompts and trigger questions to best support practitioners identify potential hidden harm to children n.
  - 3.10 Ensure that midwifery records demonstrate that discussions about domestic abuse have been undertaken, recorded and concerns reflected in care plans in line with trust policy.
  - 3.11 Ensure that the governance arrangement and the quality of referrals to the MASH from the midwifery service and ED articulate risk and concern, in order to support partner agencies with decision making.
  - 3.12 Strengthen arrangements with the local authority to ensure that midwives are supported in making timely referrals where they have identified safeguarding concerns for unborn babies.
  - 3.13 Strengthen governance arrangements to ensure that CASH practitioners are effective in their safeguarding process.
  - 3.14 Implement a robust plan to ensure that all ED practitioners have attended level three safeguarding training, and have access to a good range of additional safeguarding training relevant to their role, including CSE.
- 4. Dudley CCG in partnership with Dudley and Walsall Mental Health Trust should:**

- 4.1 Implement a specialist perinatal mental health service in line with NICE guidance, to ensure that there is appropriate support for mothers with mental health needs in Dudley.
  - 4.2 Ensure that electronic alerts are used consistently in adult mental health teams to highlight vulnerable families including those with children on child protection plans.
- 5. Dudley CCG in partnership with NHS England, Dudley Group NHS Foundation Trust, Black Country Partnership Foundation Trust and Shropshire Community Health NHS Trust:**
- 5.1 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.
- 6. Dudley CCG in partnership with Dudley and Walsall Mental Health Trust and Dudley Group NHS Foundation Trust should:**
- 6.1 Ensure that children and young people who require a mental health assessment during office hours have access to services that provide a comprehensive assessment of their needs by suitably trained and qualified staff to inform the provision of appropriate care, and to avoid unnecessary lengthy stays in hospital.
  - 6.2 Ensure that paediatric nursing practitioners have access to a copy of the CAMHS care plan, in order to better support them whilst children and young people with mental health needs are on their ward.
  - 6.3 Ensure that paediatric nursing staff at the Russells Hall Hospital, are provided with appropriate training in caring for young people with mental health difficulties and those who self-harm.
- 7. Dudley CCG should:**
- 7.1 Ensure that they continue to have health oversight in the MASH to help embed new arrangements and strengthen the opportunity for health to contribute to decision-making.
  - 7.2 Ensure that adequate resource is arranged within the role of the looked-after children's service to effectively undertake commissioned services, including quality assurance and development work.

- 7.3 Work with the LSCB to increase capacity and ensure that all health professionals have access to level three multi-agency safeguarding training that complies with the intercollegiate requirements and is commensurate with their roles and responsibilities in safeguarding children and young people.
- 8. Dudley CCG in partnership with Black Country Partnership Foundation Trust and Shropshire Community Health NHS Trust should:**
- 8.1 Ensure that all safeguarding information is filed within case records.
- 8.2 Ensure that governance arrangements for reviewing the quality of referrals to children's social care and safeguarding records are effective in raising the overall quality of safeguarding practice.
- 8.3 Ensure that health needs of children and young people are informed by SMART health plans which reflect the child's voice.
- 9. Dudley CCG in partnership with Shropshire Community Health NHS Trust should:**
- 9.1 Ensure that school nurses are aware of how to effectively use the CSE toolkit to inform their assessments of whether a child or young person is at risk of exploitation.
- 10. Dudley CCG in partnership with Dudley Group NHS Foundation Trust, Black Country Partnership Foundation Trust and Shropshire Community Health NHS Trust should:**
- 10.1 Ensure that case records include a record of the case being discussed in supervision, with SMART action plans in order to ensure that progress is being made with the case and that there is a comprehensive health record.
- 
- 

## Next steps

---

---

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