

Review of health services for Children Looked After and Safeguarding in Leicester City

Children Looked After and Safeguarding

The role of health services in Leicester City

Date of review:	8 th February 2016 - 12 th February 2016
Date of publication:	5 th August 2016
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CCGs included:	Leicester City CCG
NHS England area:	Central Midlands
CQC region:	Central
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Summary of the review

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

Where the findings relate to children and families in local authority areas other than Leicester City then 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 116 children and young people.

Context of the review

There are 342,153 people resident in the Leicester City CCG area, the majority registered with GP practices in the area. There are approximately 79,000 children and young people under the age of 18 years living in Leicester City. This is 24% of the total population in the area. Children and young people from minority ethnic groups account for 59% of all children living in the area, compared with 22% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Asian and Asian mixed and Black or Black British. The proportion of children and young people with English as an additional language in primary schools is 49% (the national average is 19%); in secondary schools it is 46% (the national average is 14%).

The Index of Multiple Deprivation (2015) ranks Leicester as the 23rd most deprived local authority in England with almost half of the population living in areas of very high deprivation. There are strong links associating economic hardship with poor lifestyle and the consequential impact on individual and family health.

Children and young people in Leicester are experiencing the impact of the wider determinants of health in six of the eight fields identified by Public Health England (2015) seeing the numbers of first time entrants to the youth justice system, children in care, and 16-18 year olds that are not in education, employment or training (NEET) all higher than the England average. There are a significant number of five year olds in Leicester who have not secured the best start with only 41.2% developing well by the end of their reception school year. Rates of infant mortality, physical activity, obesity, teenage pregnancy all appear worse than the England average.

Areas of health improvement in Leicester is also challenging for children and young people. Of significance is the number of five year old children with decayed, missing or filled teeth which is entirely preventable. Leicester has the highest rate in England scoring 51%. Tooth decay causes pain and infection, which leads to difficulties eating, speaking and sleeping. Many children have to be admitted to hospital to have decayed teeth removed. Children who come from an Asian family where parents do not have good English language skills are more likely to suffer from tooth decay, as are all those living in low-income households.

Attendances to the emergency department for 0-4 year olds is higher than the England average but the number of admissions to hospital for conditions such as asthma, injuries, mental health and self-harm were lower than the England average.

The health protection offered to two year olds and looked after children in Leicester for immunisations is achieving a greater uptake than the England average.

The Department for Education (DfE) provides annual statistics of outcome measures for children continuously looked after for at least 12 months. Strengths and difficulties questionnaires (SDQ) are used by children's social care in Leicester to assess the emotional and behavioural health of looked after children.

The SDQ score has increased year on year from 12.5 in 2012, 13.2 in 2013 to 13.8 in 2014. The most recent average SDQ score is considered to be borderline cause for concern and is below the England average of 13.9.

There are currently over 600 looked-after children and young people in the care of Leicester City Council residing in the city. This represents an increase of approximately 100 young people over the past 12 months.

Leicester's joint health and wellbeing strategy 2013-2016 identified five areas for improvement with some directly relating to children and young people. Areas intended to focus on reducing infant mortality, reducing childhood obesity and promoting healthy lifestyles, school readiness at five years of age, reducing the number of teenage conceptions, promotion of emotional wellbeing of children and young people. Data seen as part of this review indicates achievement of this to be a challenge. However it is too early to consider the full impact of the strategy on improving outcomes for children and young people in Leicester

The current climate in Leicester is challenging for the health and social care economy. The CCG confirmed during our review that there are five serious case reviews and two alternate reviews currently ongoing.

Ofsted inspected Leicester City in January 2015 for children in need of help and protection, children looked after and care leavers. Ofsted also reviewed the effectiveness of the local safeguarding children board. The overall judgement for both areas was 'inadequate'. Improvement was identified across the Leicester City partnership.

Commissioning and planning of most health services for children are carried out by Leicester City Clinical Commissioning Group.

Commissioning arrangements for looked-after children's health and the designated roles are the responsibility of NHS Leicester City CCG and health services for this are provided by Leicestershire Partnership Trust (LPT).

Acute hospital services are commissioned by Leicester City CCG and provided by University Hospitals of Leicester (UHL).

Health visiting and school nursing are commissioned by Leicester City Council (public health part of Local Authority) and provided by LPT.

Child and Adolescent Mental Health Services (CAMHS) are commissioned by Leicester City CCG and provided by LPT.

Adult Mental health Services are commissioned by East Leicestershire and Rutland CCG and provided by LPT.

Adult substance misuse service is commissioned by Leicester City Council and provided by LPT.

Integrated sexual health services are commissioned by Leicester and Leicestershire local authorities, and provided by Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP).

Urgent care is commissioned by Leicester City CCG and provided by UHL.

The Merlyn Vaz walk in centre is commissioned by Leicester City CCG and provided by SSAFA Care.

Specialist services are commissioned by NHS England – Central Midlands, and provided by a range of providers.

The last inspection of health services for Leicester's children took place in 2011 as a joint inspection with Ofsted of safeguarding and looked after children's services. Overall effectiveness of the safeguarding services was adequate and the contribution of health agencies in keeping children and young people safe was found to be good. Overall effectiveness of services for looked after children and young people was found to be good with the outcome for being healthy rated as outstanding.

The report

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

What people told us

We heard from a range of service users and carers during the review. We have captured some of their views and experiences.

In maternity we spoke to parents who told us about their experiences:

"When I went on the labour ward on Sunday and during delivery my baby's heart rate dropped, doctors and midwives were in the room, they remained calm and kept reassuring me that we were their priority and this support meant that I did not have to go to theatre".

"After care has been fine and I have been kept informed, the midwives have been helpful, honest and supportive, I could not ask for more".

Another new mother told us:

"I am always seen by different doctors [but] it would be nice to limit the number of different doctors [because] although my medical information is in my notes I continually got different advice. I was left feeling frustrated as when the community nurses came to see me at home they could not administer treatment as they did not have permission as the doctor had not recorded accurately in my notes the correct dosage of medication I needed and there was no doctor's signature. The community nurse had to get the right permission so I could receive the treatment I needed".

We heard about the experiences of partners:

One informed us:

"It has been brilliant, I have been allowed to stay over and they have let me know what was going on. Every staff member has been lovely".

Another stated:

"I am not sure what is happening today or if we are going home, you are not kept informed if you don't ask you don't find out but that is because midwives are run off their feet. The care is good but there is just not enough communication or efficiency. Why does one doctor put in the cannula but then you have to wait for an hour for the bag of fluid to be connected?"

We spoke to a young person in care who described her experience with maternity services:

"I was treated differently. People judge you but some staff are ok."

A young person in care told us about their experience of child and adolescent mental health service (CAMHS):

"I had good days and bad days. I would write down how I was feeling and show this to staff. If I was having a good day it was like they didn't believe me...about the bad days". "The crisis CAMHS listened to me more".

A looked after young person talked about the impact of being placed out of area whilst receiving CAMHS:

"I had to wait again when I moved areas and the work did not pick up where the others had left off. We had to start again".

A young person with complex needs living in a residential care setting was able to share with us how the specialist looked after children (LAC) nurses have helped her to understand and care for her body.

A young person who has left care told us about their contact with the specialist LAC nurses:

"When I left care I missed seeing the LAC nurse. She was someone I could talk to and was there for me".

A manager of a residential care home told us:

"We can contact the specialist LAC nurses if we need to. We have a primary mental health worker linked to the children's home. They help to support staff".

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 There are two formal streams of early help on offer to children, young people and families with additional needs in Leicester. One is local authority driven, with the other having more of a health focus provided by Leicester Partnership Trust (LPT) in the format of neighbourhood forums. Leicester City Children's Improvement Board is seeking assurance of the work being undertaken by frontline staff with regard to early help. Data from January (2016) indicates that whilst the number of lead practitioners had increased from 1% to 1.5% they want to increase this. They identified actions to take to understand the response of frontline staff to early help and in undertaking the role of lead professional. However, progress may be limited based on the minutes seen as there was no identified responsible person assigned to undertake this work.

1.2 Midwives in Leicester have a flexible approach to conducting antenatal appointments in a variety of settings. Home visits are arranged if appropriate. We have seen in other areas, where this is more universally offered, that it helps the midwife to better understand the women's home circumstances and the impact this may have on them or the unborn. When home visits are undertaken this can help to identify additional needs and risks for the woman and/or the unborn that could benefit from early help.

1.3 Midwives may liaise with GPs informally to share information about women they are caring for but there is no standard process or expectation that all midwives formally liaise with or inform GPs of a woman's pregnancy. Midwives can access GP IT systems and review patient records. GPs hold essential information on patients' current and historical health and social issues. However, this is reliant on the GP recording this information. Access to this information is an essential part of risk assessing women and the unborn to initiate early help or safeguarding procedures. The benefits of sharing information are well evidenced in serious case reviews.
(Recommendation 9.1)

1.4 Community midwives do not have access to complete maternity records. They cannot access the trust's maternity record keeping system E3 to support their practice when in the community. They can access E3 when they are on the hospital site. This fragmented access to women's records prevents community midwives from having a complete oversight of up to date information that may reflect escalating or de-escalating concerns. Access to a complete record reflective of needs would enable the community midwife to be more vigilant in their ongoing contacts with women and the unborn and initiate early help or child protection processes if indicated. (**Recommendation 3.1**)

1.5 Midwives demonstrated effective communication with health visitors, providing notification of all new bookings. This is important during the antenatal period, helping facilitate good engagement with vulnerable families and ensuring the provision of appropriate support at the earliest opportunity. This helps to contribute to securing the best start for new-borns.

1.6 Pregnant women who disclose they have been subject to female genital mutilation (FGM) are referred to the FGM clinic and seen by a consultant obstetrician. Where risks to the unborn are identified these women would be referred to children's social care. Midwives have access to a Leicester, Leicestershire and Rutland (LLR) LSCB tool which is based on the DoH Guidance for Professionals (2016) to assess for the risk of FGM in women they care for. However, not all midwives have received training to use the risk assessment tool. The named midwife recognises the importance of this training to ensure midwives have a consistent approach to FGM that is strongly embedded in their frontline practice to reduce the risk of variable assessment. (**Recommendation 3.11**)

1.7 Midwives are not proactive in assessing the risk of domestic abuse to women and the unborn throughout their episode of care. Pregnant women are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or sensitive social and medical issues. The trust's requirement to ask women once (when it is safe to do so) about domestic abuse is being fulfilled, but guidance from the Royal College of Midwives (RCM) suggests that women should be asked about domestic abuse throughout their period of care. It is well documented that domestic abuse risks to women may begin or escalate during pregnancy. (**Recommendation 3.13**)

1.8 Parents in Leicester benefit from targeted work to promote positive emotional and mental wellbeing as they adjust to caring for their new baby. This helps to promote good mental health and strengthen attachments with their babies. This is a high impact area outlined in the healthy child programme 0 - five years, indicating how health visitors can significantly improve outcomes for children, families and communities.

1.9 In Leicester, 51% of five year olds have tooth decay and this is currently the highest recorded incidence in England. The family nurse partnership (FNP) and health visitors have responded well to the high level of oral health inequalities experienced by local children. The school nurse team have been tasked to help establish daily supervised teeth brushing in 50% of primary schools by March 2016. However, performance data indicates that this may not be achieved. The impact of this work is unclear. The oral health of five year olds is a key public health indicator and for those affected this may cause pain and discomfort.

1.10 School nurses have not achieved their target to assess the health needs of 40% of children in the reception year at school. Data supplied stated the response rate from parents and carers for the school entry assessment was 14%. This is a significant deficit limiting the opportunity for school nurses to proactively identify health needs in this population. School readiness is a key public health priority. It is not clear what plans have been made for this cohort of children to have the opportunity to have their health needs assessed as part of the healthy child programme. ***These concerns have been brought to the attention of public health within Leicester City Council as the commissioner of the school nurse service.***

1.11 Schools in Leicester benefit from having a named school nurse linked to them. Weekly health drop-ins take place in high schools, but resources and vacancies in the school nurse team have impacted on the frequency this service is delivered. The provision in some areas has moved to a more needs led drop-in or contact, resulting in fortnightly visits to some schools. Whilst this approach enables a more efficient use of school nurse resources with provision concentrated where need is greatest, this does reduce their visibility and accessibility to children and young people in Leicester high schools.

1.12 Where agreed children and young people can access sexual health advice and support from school nurses at school drop ins. This provides young people with confidential advice and access to chlamydia screening, pregnancy testing and condom distribution which are key public health outcomes.

1.13 The development of technological systems 'Chat Health' text service and 'Health for Kids and Teens' website has increased the reach of the school nurse team. The chat system offers open and rapid access for young people who may not otherwise engage with health, with a response within 24 hours when the service is operational. Cases sampled of Chat Health highlighted clear and timely responses to young people's issues, with a clear escalation process when safeguarding concerns were identified. The website provides a rich source of information for young people, covering a range of topics such as anxiety and sharing pictures and videos online. This demonstrates innovative practice.

1.14 School nurses are not linked to colleges or further educational settings. A member of the children in care council (CICC) who attends college told us: “If I wasn’t a member of the children in care council I would not have been aware of the support and information available from the Chat Health system”. There is a risk that 16-19 year olds are not benefitting from continued access to the healthy child programme provided by school nurses. ***These concerns have been brought to the attention of public health within Leicester City Council as the commissioner of the school nurse service.***

1.15 Home educated children and young people in Leicester are not always known to the school nursing service, and are not benefitting from the offer of the healthy child programme. This lack of oversight prevents the proactive identification of additional needs in this often vulnerable group of children and young people whether they are health related or safeguarding needs. An absence of effective professional oversight of the needs of home educated children has been a feature of serious case reviews (SCRs). ***These concerns have been brought to the attention of public health within Leicester City Council as the commissioner of the school nurse service.***

1.16 Children and young people up to 16 years can directly access the dedicated paediatric emergency department (ED). The unit is bright and well equipped, with a discreet waiting area for teenagers that is within sight of receptionists and practitioners. Those children that are brought to the hospital’s urgent care centre are triaged and, where appropriate, offered a GP appointment. However, they are immediately transferred to the paediatric ED if it is felt that more specialist advice, care or treatment is needed. A member of the urgent care staff accompanies the family to the ED to safely hand over care. This good practice provides some assurance that children and young people are directed to receive care from the most appropriate service for their need.

1.17 Paediatric liaison forms are completed by ED staff when it is identified that a child or young person may benefit from additional early support, and are forwarded to the relevant community team. We saw appropriate identification of the need for support and onward referral. All attendances of children and young people under 16 are reviewed by paediatric staff during the night shift. This second look ensures that there have been no missed opportunities to identify and respond to emerging concerns.

1.18 Children and young people who need an x-ray are able to wait in a dedicated area providing a safe place away from adults who may also be waiting for an x-ray. The resuscitation area in ED has three beds that are set up specifically to provide care and treatment to children and young people. Paediatric ‘grab boxes’ are easily accessed and clearly labelled.

1.19 Those under 16 requiring a longer period of observation are admitted to the children’s assessment unit. This includes those who have attended the ED following self-harm or an overdose. This ensures children and young people are not waiting for prolonged periods of time in the ED. Those aged 16 and 17 are admitted to the emergency decision unit. All children and young people requiring CAMHS assessment have this undertaken when medically fit prior to discharge.

1.20 Practitioners at the Merlyn Vaz walk in centre (WIC) demonstrated the provision of a responsive service that is aware of the cultural and language needs of its local population and service users. Staff recruitment and shift patterns are planned accordingly to facilitate equality of access for all parts of the community.

1.21 There is no opportunity to review all under 18 WIC attendances to ensure all vulnerabilities and safeguarding risks have been identified. The good practice we saw in the ED where all attendances of those aged under 16 are reviewed was not seen to be undertaken at the WIC. The opportunity of a 'second look' at children and young people's attendances can provide assurance that the service is meeting its requirement to safeguarding children and reflects stronger governance. In particular, WIC staff may not have the appropriate sharing rights to see the children and young person's record to detect other matters of concern. Information sharing is a consistent theme identified in serious case reviews. **(Recommendation 5.1)**

1.22 Notification processes and further actions that may be required following the attendance of children and young people at the ED and WIC are inconsistent. Whilst GPs receive notification of the attendance of children and young people at the WIC and ED, there can be delays in receiving the electronic notification. GPs we spoke to stated that patterns of multiple attendances to the ED and WIC would not necessarily be identified or acted upon by the GP if the treating practitioner at the ED or WIC had not documented any concerns. There is a potential therefore that those children and young people accessing multiple settings may have significant safeguarding issues that may be missed. GPs may place an over-reliance that ED or WIC staff will have assessed and considered safeguarding concerns **(Recommendation 1.2, 4.1)**

1.23 Temporary patients registering at the GP practices we visited are not routinely asked if they have a social worker involved with their family or child. Routinely requesting this information would enable the records of vulnerable children and young people to be flagged and promote information sharing with social workers. In the GP practices we visited the electronic flagging facilities on SystemOne were used effectively. This aids the identification of vulnerable children and young people, looked after children and those with safeguarding and child protection issues. **(Recommendation 4.2)**

1.24 GP referrals for adults made to the mental health and substance misuse service did not consistently identify children and young people in the household. This omission may render children invisible despite living with, or having connections to, adults presenting with concerning behaviours and health conditions. This demonstrates that 'think family' is not consistently embedded in primary care practices. **(Recommendation 6.3)**

1.25 Recording details of the adult accompanying a child to a GP appointment is not consistently undertaken. It is not sufficient to record that the accompanying adult is "mum" or "dad". Recording the full name and relationship of the adult to the child is important, as is ascertaining parental responsibility and who is able to consent to treatment. In a fractured family with complex dynamics, the recording of the accompanying adults name is as relevant as the reported relationship. **(Recommendation 4.3)**

1.26 Young people in Leicester City have good access to a central hub- based Integrated Sexual Health Service (ISHS) through a range of walk-in and appointment based clinics. Young people needing lower level sexual health support have access to eight specialist GP practices contracted by Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP). These GPs are appropriately trained and will signpost young people needing a higher level of support back to the ISHS hub. The service reports good relationships and clear pathways established with these specialist GPs, but told us that the awareness of other GPs of sexual health issues and the effectiveness of their signposting is variable. Outreach ISHS clinics (choices) are operated across the city in youth clubs, colleges and secondary schools. SSOTP reported that changes across the educational landscape have affected the universal offer they provide to secondary schools in Leicester City.

1.27 In the ISHS all young people under 16 years are fast-tracked in order that they access services promptly as waiting increases the risk the young person will leave before being seen. This is good child safeguarding practice.

1.28 Adult mental health practitioners in Leicestershire Partnership NHS Trust (LPT) do not routinely share copies of relapse, crisis and contingency plans to support other professionals such as health visitors to identify early signs of deteriorating mental health in their clients. This is a missed opportunity to strengthen multi-disciplinary support to families where mental health or substance misuse is a factor. One plan seen was of poor quality. It did not state how best to identify and support deteriorating mental health in the client and did not consider the children either in relation to the adult's mental wellbeing or from a child safeguarding perspective. (**Recommendation 2.4**)

1.29 Leicester Recovery Partnership (LRP) provides substance misuse services for people living in Leicester City and support to families and carers. The partnership is made up of Leicestershire Partnership NHS Trust and two third sector organisations, Phoenix Futures and Reaching People. This approach helps to support clients with children on a number of social issues while they receive intervention on tackling their substance misuse.

1.30 LRP substance misuse services do not routinely notify health visitors or school nurses of adult clients with dependent children or who have contact with children and young people. The sharing of such information would enable health visitors and school nurses to consider other vulnerabilities for the child. (**Recommendation 10.1**) ***These concerns have been brought to the attention of public health within Leicester City Council***

Case example from adult mental health

In the adult mental health service, we saw a case example of good liaison and partnership working with health and education services to secure positive outcomes for a woman, her child and her unborn baby.

A woman was in denial about her third pregnancy believing the baby was not hers and was expressing paranoid thoughts about her doctor. Her eldest child was four years old having lost her second child.

We saw that details of the children were visible having been captured by the practitioner in the front of the care plan. This provided a high profile on key documents that practitioners and managers accessing the record are likely to see quickly. This was also shared with other professionals. However there was no 'flagging' of risk seen on the record.

The case was not taken on by the small specialist consultant led perinatal mental health service as the mother was already known to the adult mental health service with a pre-diagnosed mental illness. There was however, excellent support and co-ordinated work between adult mental health and the specialist perinatal mental health midwife.

We saw evidence of liaison and good partnership working with health visitor and the school special educational needs co-ordinator. The adult mental health practitioner worked closely with midwifery and other antenatal clinicians to ensure a healthy foetus while supporting mum's mental health, thus helping to facilitate positive bonding and attachment between mother and baby.

Following delivery of the baby the mother continues to successfully parent her baby with the support of health professionals in an effective team around the family (TAF).

2. Children in need

2.1 Health staff were not consistently communicating concerns for safeguarding children and young people. Effective multi-agency working and communication between partners did not appear embedded outside the formal procedures of child in need (CiN) or child protection. ***(Recommendation 6.1) These concerns have also been brought to the attention of public health within Leicester City Council***

Case example: We tracked a case through school nursing and CAMHS.

A 16 year old young person with complex needs who attends a special needs school was referred by his GP in February 2015 to the community paediatrician. At the single point of contact an additional referral to neighbourhood lead and school nurse was initiated. Contact from the neighbourhood team did not happen until May 2015. A care navigator (administrative staff) trained to level two in safeguarding children contacted the young person's parent who disclosed the young person hits his younger siblings. The care navigator and the neighbourhood team failed to analyse and consider the safeguarding risks to the younger siblings (11 years of age and a toddler) who were potentially at risk of further harm.

In November 2015 the parent made another disclosure to the CAMHS stating her 16 year old was hitting his 11 year old sibling. This appropriately led to a referral to children's social care. The referral contained very limited information about risk of harm to the younger siblings with no up to date risk assessment that was inclusive of potential or actual risks to the younger siblings and family. We saw no evidence of the outcome of this referral or dynamic pursuit from CAMHS to secure an assessment of the needs and risks in this family from children's social care.

The GP made a referral to children's services in January 2016 at the mothers request for support for the needs of the 16 year old with no reference made to needs or risks to the younger siblings.

Despite contact from at least four different health professionals we saw no evidence of any effective joined up working with no indication of any one single health professional maintaining a dynamic oversight for the needs of this young person and his siblings. Communication and information sharing between agencies and the GP regarding risks was poor with staff missing the opportunity to intervene early.

Staff told us about their concerns for risks around the duties and responsibilities being undertaken by care navigators. This does not appear to have been escalated or subjected to any formal review.

2.2 There are a good range of specialist midwifery posts at Leicester Royal Infirmary (LRI). These specialist midwives act as expert resources for the wider maternity team and hold complex cases in the antenatal period. Vulnerable women are well supported and receive co-ordinated services throughout their period of care. This is good practice.

2.3 There are a range of joint consultant and specialist midwifery clinics for vulnerable women to access at the LRI. Joint clinics help to reduce the overall number of appointments for women. This is effective in helping to keep expectant women engaged in their antenatal care.

2.4 Police attendance at domestic abuse incidents where a pregnant woman or new-born baby is present are not routinely shared with the maternity safeguarding team. This lack of information may negatively impact on midwives assisting women to access appropriate support and in their ongoing assessment of safeguarding risks. Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy. **(Recommendation 3.16)**

Domestic abuse notifications are not routinely shared with health visiting and school nursing staff. Notifications of higher risk cases at multi-agency risk assessment conference (MARAC) are made, but this reactionary approach to information sharing greatly restricts the opportunity for health staff to offer proactive early help to children and young people. **(Recommendation 2.19) These concerns have been brought to the attention of public health within Leicester City Council.**

2.5 Children and young people in Leicester experience delays in receiving support from the CAMHS. As a consequence universal services such as GPs, health visitors and school nurses often continue to provide support to children and young people. This is not an effective solution when their needs require assessment and intervention by targeted or specialist CAMHS teams. **(Recommendation 2.16)**

2.6 Children and young people of school age are at risk of not receiving an appropriate review of health needs by school nurses following attendances at the ED, UCC and WIC. Whilst the standard operating procedure sets out some operational practice around action required, this has not been embedded in practice. As a consequence there is a risk of escalating unmet health or safeguarding needs in children and young people discharged from emergency department, minor injuries unit and UCC. **(Recommendation 1.2) These concerns have been brought to the attention of public health within Leicester City Council.**

2.7 In the emergency department, UCC and the WIC there is an absence of any universal safeguarding prompts to support staff to assess for risks to children and young people. Assessment is reliant on individual practitioner professional curiosity to explore and analyse child safeguarding risks. Whilst this may be expected custom and practice the ED were not able to provide assurance of their ongoing effectiveness as they are not monitoring the child safeguarding performance of staff. Positively we saw some case evidence in the ED of exploration of risk at initial assessment but this was not evident in the case records of older children and young people; staff did not record if they had considered or excluded risks such as child sexual exploitation (CSE). Furthermore, in sampled records of adults attending with concerning behaviours practitioners did not consistently record the full details of children that may be at risk of harm as a consequence of the adult's condition. For example in the latest attendance of an adult following an overdose in the presence of their children the adult ED practitioner appropriately identified that there were children in the family and had referred to the trust's safeguarding team. However, it was noted that there were two previous attendances where details of the children had not been established and not referred to the safeguarding team. This meant that the opportunity to intervene earlier had been missed. There is an overreliance on the judgement of the examining doctor or practitioner to be inclusive of child safeguarding risks and hidden harm in their assessment. This is not robust safeguarding practice. (**Recommendation 1.1**)

2.8 Children, young people and families accessing support from the adult mental health assertive outreach team benefit from an approach that profiles children high in their work. This has been underpinned by the team lead for children undertaking 'wrap around the family' training with Leicester City Children's Social Care. This keeps the child visible in vulnerable family situations. This is vital to effectively safeguard children and young people. Further developments will see the practitioner having access to the children's social care information system. This will enable the assertive outreach team working with highly complex and challenging families to be well informed by current social care information. This further strengthens their good safeguarding practice.

3. Child protection

3.1 Written referrals and reports made to children's social care are of variable quality and did not consistently articulate risk. Referrals and reports sent from LPT services do not benefit from the same level of oversight offered by the safeguarding team for those sent from UHL. We saw gaps in some sections of child protection reports rendering the document to be incomplete. Referrals sent from maternity are triaged by the maternity safeguarding team, but this could be further strengthened by utilising the LSCB threshold document to underpin concerns and risks. A benchmarked standard would improve practice helping to secure a stronger timely response from children's services and reduce the number of no further action outcomes from referrals made. ***(Recommendation 2.1) These concerns have also been brought to the attention of public health within Leicester City Council.***

Case example from school nursing

A child protection report seen in school nursing lacked detail and was incomplete.

The nurse appropriately included concern that the child had missed health appointments but this could have been further strengthened with the addition of more information and analysis, such as the number of appointments missed with the significance and impact on the child.

The section regarding the child's social and emotional health was not completed. Staff reported that the nurse had met the child once and did not know him well enough to comment.

Whilst the nurse may not have known the child well, the inclusion of her professional views and concerns regarding the impact of his ongoing soiling and missed health appointments on the child's social and emotional health may have informed the multi-agency decision making process.

Omitting such information weakens the impact health professionals have in contributing to effective multi-agency safeguarding practice.

3.2 Midwives do not consistently have access to important child protection decisions that impact on those in their care. Copies of reports and outcomes for initial and review child protection case conference and outcomes were not held within patient notes. This prevents midwives from being fully informed of current child protection risks and concerns for the unborn or new-born in their care. Copies of referrals made to children's social care were seen within medical records, and overall these were of good quality and clearly articulated risk. ***(Recommendation 3.1)***

3.3 We saw within maternity notes robust safeguarding birth plans. These are held electronically, in medical notes and shared with community midwives. In paper records safeguarding entries were clearly identifiable by the use of a blue sticker stating 'safeguarding update'. This helps to increase the visibility of safeguarding information to practitioners accessing the records and providing care.

3.4 The discharge of medically fit mothers and babies can be delayed while children's social care arrange placements or apply for care orders. Extended in-patient stays for medically fit women and babies for social reasons are not appropriate. (**Recommendation 3.2**)

3.5 Health visitors, alongside midwives, are working to strengthen identification of, and support for, women and girls who have experienced or are at risk of FGM. In neighbourhoods across the city, health visitors are working closely with individuals and groups to open up discussions about FGM as part of a preventative safeguarding approach. We saw in health visiting an improved awareness of FGM incidence and evidence of some sensitive casework to support mothers who have experienced this.

3.6 The Family Nurse Partnership (FNP) work effectively in engaging with parents to develop parenting skills and promote good attachment. One case seen demonstrated that with FNP support a family were stepped down from child protection to CiN. Whilst undertaking these reviews we consistently see the positive impact FNP services are having in helping to secure the best start for those they have contact with.

3.7 The LPT 'Chat Health' service have clear processes in place to guide practitioners responding to messages indicating a child or young person could be at risk of significant harm. This has been used when messages of concern were received that required Police welfare checks to be made. This demonstrates good partnership working and strong governance arrangements.

3.8 Children and young people who attend the ED following substance or alcohol misuse are routinely referred to children's social care. The local young people's substance misuse service attend the ED regularly to pick up details of any young person who has asked or agreed to be referred to their service. This helps to engage the young person in accessing support.

3.9 Environmental assessments have not been carried out in the paediatric areas to ensure that a child or young person with self-harm or suicidal ideation can be kept safe. This is not NICE compliant. The achievement of this rests jointly with service providers, health practitioners and commissioners. (**Recommendation 3.3**)

3.10 There is no designated 'place of safety' for children under 18 in the Leicester City area. Children and young people who attend with significant mental health concerns and need a specialist CAMHS in-patient bed are usually cared for in the paediatric ED until a designated place of safety can be found. In the last year, eight children and young people were admitted to adult mental health wards until an appropriate bed could be found. Those children and young people requiring admission that cannot be accommodated locally may be transferred out of area. This can isolate the young person from the support of their family and friends.
(Recommendation 4.7)

3.11 Effective arrangements are in place within the UHL safeguarding team to screen referrals made by staff to DAS. This oversight ensures that referrals contain as much supporting information as possible to inform decision making and enable a timely response. The trust's safeguarding database is effective in managing workflow and making links to family members, including those adults who may have caring responsibilities but not living at the same address as a child. Inspectors reviewed the database and found this a useful tool in facilitating safeguarding within the organisation.

3.12 In the ED completed referrals to children's social care are also notified to the relevant health visitor and school nursing teams. However, we were not assured that health visitors and school nurses were consistently following up and recording any actions taken to inform care planning for children and young people.
(Recommendation 2.20) These concerns have been brought to the attention of public health within Leicester City Council.

Case example from the ED

A parent attended the ED with alcohol intoxication. She disclosed that she lived with her partner and young children but would not give any additional detail. ED staff completed an A form and also a paediatric liaison form. This was forwarded to the trust's safeguarding team.

The safeguarding team established from their database that the mother had attended the ED with similar concerns over a year ago and that the safeguarding team had identified the names and addresses of the children and also of the partner.

This important information was then included on the A form and shared with children's social care.

We were able to establish that a year prior to this latest attendance the children had been on a child protection plan that had been discontinued because the mother had abstained from alcohol and had made good progress in keeping her children safe.

The details of this relapse were shared with the health visitor. However, the records indicated no further action was taken by the health visitor.

We did not see evidence of any outcome or who was continuing to maintain oversight of this case

3.13 In the WIC they reported concern regarding delays in accessing the crisis CAMHS for children and young people presenting in mental health crisis. This is challenging for both clients and staff as the environment in the WIC is not suitable, and it is not appropriate for children and young people who are mentally ill to wait for assessment in the care of staff who provide tier one level of support.

(Recommendation 8.1)

3.14 Young people who have been the victims of sexual assault are benefitting from an informed and responsive health service that ensures their specialist needs are met. There are established pathways between SSOTP ISHS and the sexual assault referral centre (SARC) with community paediatricians engaged in sexual assault examinations. The service reports good links with the local SARC at Juniper Lodge and the SARC at Northampton General Hospital.

3.15 SSOTP sexual health services have a clear and explicit protocol that supports staff to make referrals into DAS when they identify potential risks to children and young people. This facilitates staff in crystallising their thoughts and concerns about the risks of harm to the child and set these down succinctly. This is also useful to the practitioner in helping them in articulating their concerns more clearly in the telephone discussion with the DAS.

3.16 The 'did not attend' policies (DNA) in adult mental health do not sufficiently consider risks to children and young people or those known to be subject of CiN or child protection plans. For example, the DNA policy in the assertive outreach (AO) team is specifically tailored to the service model and cohort of clients. Whilst it is understandable that adult services consider adult safeguarding risks, in DNA policies a 'think family' approach would also support the inclusion of risks to dependent children. This would support practitioners to take agreed action to effectively safeguard children, young people and adults. (**Recommendation 2.3**)

3.17 Adult mental health's information recording system does not sufficiently support the embedding of a "think family" model. Children's details do not appear on the demographic page for the client and there is a risk that the child or young person will be hidden in the record. We saw in case records that some practitioners include the details and dates of birth for children within a family or household at the front of the client's care plan. This helps to keep the profile of children and young people high within individual cases. It is an explicit expectation that practitioners will identify children within the household and not just those for whom the client has parental responsibility. (**Recommendation 6.3**)

3.18 Adult mental health in-patient facilities have good family room provision. This is positive and helps to support and sustain good family relationships between parents receiving treatment and children visiting for contact.

3.19 In adult mental health it was not always clear that actions arising from child protection case conferences attributed to the service had been included in the adult's care plan. Including this in care plans facilitates a more holistic joined up approach to care provision. Lack of clarity about professionals' roles and responsibilities in child protection cases is a common feature of serious case reviews. (**Recommendation 2.2**)

Case example from mental health

An adult mental health clinician was concerned that their client was a potential risk to children and the public. The client had a pending court case for an offence linked to current and historical concerns.

The clinician had significant concerns about the potential risks posed by the client to vulnerable adults and children as the client. This was increasing as the client was being prepared for discharge back into the community.

There has not been a face to face professionals meeting between adult mental health, Police and children's social care to share information and concerns about the client, despite this being requested more than once by the adult mental health clinician.

We did not see the application of the escalation policy or any discussions with the trust's safeguarding team.

The case remains very complex with risks not fully understood. We sought a managerial response from health and social care for assurance that all potential safeguarding risks have been addressed.

3.20 The case example below demonstrated that frontline health staff in LRP have a variable understanding of the process and pathway to make referrals to children's social care when they identify those in need or at risk of harm. As a consequence, those unborn, children and young people are at risk of encountering avoidable delays in having their needs and risks assessed by children's social care and may not be adequately safeguarded. ***(Recommendation 10.2) These concerns have been brought to the attention of public health within Leicester City Council.***

Case example from LRP

An LRP practitioner identified that a pregnant client with additional vulnerabilities was also relapsing back into heroin use required a referral to the children's social care duty and advice (DAS) service to help safeguard the unborn.

The LRP practitioner appropriately identified risks to the unborn as a consequence of the woman's behaviours and followed the protocol to make a verbal referral to the DAS. The case record reflected that the call was made, including areas discussed with the social care practitioner. However, it did not state what the outcome of this discussion was; whether the referral was accepted or declined. It appears to have been an information sharing discussion. At the time the LRP practitioner believed that she had made a referral but it had been 'refused', so did not complete an inter-agency referral form but made a referral to sure start.

We did not see any evidence that the practitioner escalated this through the appropriate safeguarding team or any liaison with safeguarding midwives.

The LRP practitioner made another referral to DAS a month later using the interagency referral form. Whilst the quality of the content could have been stronger to articulate the risk of harm to the unborn this was accepted and social worker was allocated.

As a consequence of misinterpretation of the referral process to children's social care the unborn encountered a delay in having risks assessed.

3.21 There is a clear expectation by LRP managers and practitioners that they will be members of core groups and attend CiN and child protection case conferences. Practitioners are expected to submit written reports ahead of conferences in line with best practice and we saw good evidence of this in records. If the practitioner is unable to attend or needs support, the enhanced family practitioner will attend in their place or accompany the practitioner. This is positive and supportive safeguarding practice.

3.22 LRP staff are not consistently invited to strategy discussions in cases where adult substance misuse practitioners are working closely with an adult. The practitioner may hold key information about the adult that is central to the safety and wellbeing of a vulnerable child. This reduces the impact of effective multi-agency decision making across the partnership. ***(Recommendation 10.2) These concerns have been brought to the attention of public health within Leicester City Council.***

3.23 LRP practitioners are not always recording and analysing the adult's perception of their substance misuse on the child. This restricts the opportunity to consider the child who may be affected by the adult's behaviour. There was no indication that this deficit had been identified by operational oversight of practice or auditing of records. ***(Recommendation 10.2) These concerns have been brought to the attention of public health within Leicester City Council.***

3.24 LRP practitioners and school nurses are under-utilising the flagging and safeguarding facilities available on the SystmOne electronic record. This is a missed opportunity to increase the visibility of safeguarding alerts to other practitioners using the record locally and nationally. ***(Recommendation 10.3) These concerns have been brought to the attention of public health within Leicester City Council.***

3.25 Home visits are universally undertaken by LRP practitioners when they are aware of children within the family or household of adult clients regardless of whether additional vulnerabilities have been identified. This helps practitioners to assess the home situation and consider if there are other vulnerabilities. This is good practice in keeping children and young people safe.

3.26 We visited two general practices and found their awareness of safeguarding and child protection was good. Regular multi professional meetings to discuss vulnerable children and families were held at these practices. Meetings are minuted and actions recorded on patient records. We saw the benefits of having shares in place on the SystmOne GP record enabling effective liaison and the exchange of information between primary care and health visiting / school nursing / midwifery services.

3.27 Strategy meetings are held by teleconferencing due to the difficulties of getting agencies together. This approach is helping to increase health practitioners' engagement in strategy discussions. This ensures that key health information is considered as part of the decision making process about how best to support the child.

3.28 In health services the "think family" model appeared more aspirational than embedded in practice. On the whole, the model was underdeveloped with some poor practice seen. This was demonstrated in cases we tracked and cases we sampled throughout the review. ***(Recommendation 6.3) These concerns have been brought to the attention of public health within Leicester City Council.***

Case example from adult mental health and maternity

The inspector and the head of nursing reviewed a case in adult mental health of an in-patient that identified high risk concerns requiring immediate action.

An adult male with a family was known to mental health services following an admission last year. We tracked the case back and identified that there had been excellent multi-disciplinary working at the time of his discharge in 2015 but thereafter there is no evidence of any communication between adult mental health and any other services such as midwifery, health visiting and children's social care.

The male was admitted for in-patient treatment for psychosis and visual hallucinations. He had expressed verbal threats to kill his family. It was known that there had been domestic violence in the relationship. The male soon after his admission told staff of his wife's pregnancy and that she was approaching her due date. At that point the status of the unborn and siblings was not known. An entry in the adult mental health record claimed the social worker was planning to put the two children into foster care while the mother had the baby as she was struggling to cope.

The birth date of the new-born was noted and the baby was reportedly subject to a child in need plan.

The inspector noted an entry in the adult mental health record reporting the male was to visit his new-born baby and wife on the maternity unit that day, yet the record indicated he may still be a risk to his family and possibly others. Immediately attempts were made to delay this but it was found that he had already visited the maternity unit unaccompanied. The record revealed no evidence of any robust risk assessment to underpin the permission granted by the psychiatrist for the male to visit his wife and new-born unaccompanied.

There does not appear to have been a properly co-ordinated and fully risk assessed multi-agency plan to facilitate safe visits by the male to the maternity ward despite the presence of significant safeguarding risks.

The case was escalated back through the CCG to ensure safety and that appropriate action was taken to assess and reduce risk of harm, requesting a managerial response from health and social care. This secured further cross agency analysis of the case. The CCG will monitor progress.

This case exposed areas of poor child safeguarding practice around information sharing, liaison, risk assessment and think family. These are common themes highlighted in serious case reviews

4. Looked after children

4.1 The timeliness of initial health assessments (IHAs) is not meeting the national standard. Children and young people at the start of their care journey are not consistently having their health needs assessed and risk delays in having any unmet health needs addressed. In April 2015 zero IHAs were completed within 28 days of a child coming into care. Performance had significantly improved to 65% in November 2015 but in January 2016 this dropped to 48%. The provider trust has responded well by creating additional IHA clinics. Progress, though, continues to be hindered by ongoing poor communication systems between the local authorities looked after children's services and health. Delays in receiving notifications prevent the provider trust from planning clinics and completing IHAs that contribute to improving the health outcomes of children looked after. (**Recommendation 2.6**)

4.2 Children and young people placed out of county are not consistently having their health needs assessed as per national timescales and guidance. Reciprocal arrangements are not in place in some other local authority areas. Delays in undertaking review health assessments (RHA) can prevent the identification of ongoing or emerging health needs preventing children looked after from achieving and sustaining optimum health. (**Recommendation 2.6**)

4.3 Children looked after who move placement within Leicester benefit where possible in retaining their original looked after children's (LAC) nurse. Each such case is decided according to the best interest of the child or young person. This can be really helpful to young people who are living in unstable situations as the specialist LAC nurse may be the only stable factor in their lives. Cases examined demonstrated child centred practice, underpinned by in depth knowledge of the specialist nurse.

4.4 The specialist LAC nurse team is operating under significant capacity pressures, reporting increasingly complex cases requiring greater support and intervention. The CCG undertook a review of the LAC service but the final report is yet to be published. Furthermore, Leicester has been selected for the relocation of around 300 asylum seeking children and young people. Timescales, workforce planning and commissioning have yet to be established to meet the health needs of these children and young people.

4.5 Health support to care leavers is underdeveloped. Leaving care health summaries were introduced in 2015 and are based on models successfully used in other areas. Practitioners told us they want to do these thoroughly but the timely achievement of this is hindered by significant capacity pressures. As a consequence there is a backlog whereby young people about to leave care or having already left are waiting months to receive their health summary. The delay in such important information being shared is not acceptable. (**Recommendation 2.7**)

4.6 There is a disconnect within the children looked-after service that prevents the specialist and designated LAC team from having a full overview of the health needs of the 0-18 children looked after population of Leicester City. Current IT systems and processes do not support ease of access to the health records of 0-five year old and unaccompanied asylum seeking children looked after. This is a significant barrier to maintaining effective governance and a complete operational oversight of the needs of these vulnerable children and young people. This renders these children invisible to the children looked-after team and therefore they were unable to provide assurance that their health needs were being met as identified in their health assessments. **(Recommendation 2.8)**

4.7 There is specialist support for unaccompanied asylum seeker children (UASC) over the age of 16 years of age. This support can extend beyond the age of 18 years. This is positive as it helps to prepare the young person for adulthood and greater independence. However, the LAC service was unable to identify the cohort of UASC within the database, although individual specialist nurses know when they have UASC on their caseload. We saw evidence of positive work carried out with an unaccompanied asylum seeker around night time enuresis leading to improved management. A positive relationship had been developed by the nurse with the young person who wanted to have one to one input on relationship and sex education.

4.8 The quality of initial and review health assessments across the 0-18 LAC service is of a variable standard. Existing quality assurance processes are not sustaining or improving the quality of the assessments undertaken. RHAs sampled appeared episodic in nature with little or no connection made to the previous RHA. Health action plans seen were not consistently SMART with some missed opportunities to be more inclusive of public health issues and sustaining optimum health. Good quality, dynamic, co-produced health assessments can improve the short and long term health outcomes for LAC. **(Recommendation 2.9) These concerns have been brought to the attention of public health within Leicester City Council.**

Case example

We saw case evidence of good partnership working between health visitors in their LAC role with social workers.

In one case there were concerns about the impact of maternal substance misuse and domestic violence on the unborn leading to pre-birth plan that would place the baby in care at birth.

The health visitor attended the mother and baby in the hospital in line with the neonatal pathway and participated in all pre-birth planning meetings including child protection case conferences and looked-after child statutory reviews.

The health visitor provided good support to the foster carer with positive progress made now seeing the mother having contact with her baby three times a week.

4.9 Carers of LAC have variable access to support that helps them manage the health needs of children and young people with conditions such as allergies. This is concerning as children and young people often come into care not having benefitted from the best start and should be afforded care that improves their health outcomes. However, the specialist LAC nurses do deliver three core training sessions per year to carers covering issues such as eating well, sexual health and relationships and neglect and looking at attachment disorder and its impact on child behaviours. **(Recommendation 2.10)**

4.10 Strength and difficulty questionnaires are not routinely shared by LAC local authority staff to inform the RHA. Access to this information can help underpin the health assessment process enabling children, young people and practitioners to track their emotional wellbeing and initiate early help if indicated. The specialist LAC nurses have received training around supporting the emotional and mental health needs of children looked after.

4.11 The specialist LAC team have good access to CAMHS and are able to make direct referrals. They can access CAMHS supervision and meet regularly to discuss cases of children looked after in residential settings. We saw evidence that CAMHS provide carefully considered and sensitive work to children looked after, although there is no fast track access. In one case the worker recognised the vulnerability and cultural needs of a young person with complex needs, maximising the most of the time he has remaining in care to help him prepare for adulthood.

4.12 The LAC service demonstrates good engagement with children looked after. They joined the children in care council at the request of the members and are actively involved. Furthermore the LAC team used a trust initiative, 'listen in action', to help use feedback from children looked after to improve the service offered. As a result staff held an event in October 2015 for children looked after to gather their views and experiences. This revealed that they preferred their health assessments to take place at home. The LAC team have responded positively to this giving children looked after greater choice about the location of their review health assessment. Children looked after also suggested using social media and tablets to involve them more directly in completing health assessments and positively funding was secured to purchase iPads to help achieve this.

4.13 There is a specialist smoking cessation service for children and young people who are looked-after, delivered by LCC. A dedicated worker visits residential homes, foster carer homes and schools providing one to one support for children looked-after. Support to quit is also offered to carers. This is a service that can help to deliver good outcomes for the cohort of looked-after children which often has a high proportion of smokers, particularly where there is a significant provision in residential care. Certainly the incidence of smoking among residential staff has reduced as a result of this service with staff modelling behaviours conducive to young people adopting a healthy lifestyle. The service evaluates very well with young people.

4.14 SSOTP's sexual health services works closely with the LPT specialist LAC nurses and the FNP to help engage reluctant young people with sexual health services. Practitioners work collaboratively in a very individual young person focused way and are creative in how and where they can support the young person. LAC specialist nurses have tier one sexual health training, enabling them to give lower level sexual health support, advice and guidance to young people with whom they have often developed an established relationship of trust. This is very positive, promoting good sexual health well to a cohort of young people known to have heightened vulnerability in this aspect of life.

4.15 GPs are not routinely asked to contribute to initial or review health assessments. As the primary record holder, it is important that the GP's have the opportunity to provide input to the health assessment process. This collaborative approach would ensure that GPs have a good oversight of the needs of LAC registered at their practice. (**Recommendation 2.11, 4.4**)

Case example from LAC service

An IHA undertaken by a locum community paediatrician for a baby was of a poor standard.

The documentation was very badly hand written and illegible in a number of places, rendering the potentially vital clinical information useless. In other cases we saw typed summaries had also been completed. However, for this case there was no typed summary in the record.

The assessment failed to capture clearly the ethnicity of mother and baby with no information recorded about the child's father. This could provide the baby with important information when they leave care. However the legal status of the baby and reason why they became looked after was recorded. The health plan was poor with no SMART time limited objectives or clear accountabilities. The assessment and plan had been signed off by the designated doctor for looked-after child.

The quality of this IHA was poor. As a consequence we referred this case back to the designated doctor for an immediate review. We requested that the baby was in receipt of a clear comprehensive and legible health assessment with a SMART health action plan that sufficiently meets their needs.

There was every reason to ensure that this new born had a thorough and good quality IHA, but this had not happened and issues of quality had not been identified and acted upon by the designated doctor.

Designated and named professionals have responsibility to ensure that health assessments for LAC are timely and are of quality (Promoting the Health and Wellbeing of Looked-After Children 2015).

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 There has been no continuous or dynamic JSNA process in Leicester for children and young people. Whilst there is no requirement to regularly update and refresh the JSNA, priorities and local need should continue to inform the planning and commissioning of services for children and young people of Leicester. The joint health and wellbeing strategy (JHWS) 2013 – 2016 appropriately identifies key priority areas for improving the health outcomes of the population. It pays specific attention to improving outcomes for children and young people. There are clear challenges to achieving the ambitions set out given the influence of the wider determinants of health on children and young people living in Leicester.

5.1.2 There are currently an unprecedented number of serious case reviews (SCR) being finalised in Leicester City. The partnership is considering how to share the review reports and how best to disseminate and embed the learning. We were told that nineteen themes had been identified. We saw evidence that the CCG had to secure extensions for the completion of some individual management responses (IMR). This clearly will have impacted on achieving the required timescales for undertaking this work. It is not clear if the extensions prevented the early identification of initial lessons learnt and contributed to further delay publishing the findings.

5.1.3 There is no consistent health representation co-located in the DAS. Progress has been made in accessing health to contribute to joint multi-agency decision making, with the DAS able to contact the safeguarding team as a portal into health services. Furthermore the safeguarding role of school nurses has expanded to include attendance at strategy meetings or discussions. Whilst this is a positive response, this has increased their activity with no additional resources provided.

5.1.4 The CCG reports that a positive partnership is in place between the LSCB and director of children's services, with a good interface between children and adult safeguarding. The chair of the LSCB described the positive contribution the designated nurse has made. The CCG is attending the LSCB routinely with membership at an appropriate level of seniority. The director of nursing and the safeguarding consultant / designated nurse chair a number of LSCB sub-groups.

5.1.5 The director of nursing in the CCG provides strong leadership, helping to drive improvement. The director of nursing holds regular monthly meetings with designated professionals to discuss a range of issues. We heard from NHS England of the impact the director of nursing has made in positively challenging others to improve their performance to more effectively discharge their duties. She chairs the quarterly safeguarding commissioning group maintaining oversight of plans commissioning strategies.

5.1.6 Safeguarding leadership and governance across Leicester, Leicestershire and Rutland (LLR) and provided through the CCG safeguarding team has been strengthened. An external review commissioned by the CCG and undertaken last year has resulted in additional resources being invested in the CCG safeguarding team with the addition of a new post.

5.1.7 There are three designated nurses linked to the three CCGs for LLR. They undertake core responsibilities and work in partnership to fulfil additional enhanced responsibilities set out in individual portfolios. There is one designated consultant nurse hosted by Leicester City CCG linked to UHL.

5.1.8 In the light of the high number of SCR and alternative reviews the CCG are missing the opportunity to report on safeguarding risks to the population and record their proactive response to reduce the risk. The CCG strategic safeguarding group report on key safeguarding risks and performance in Leicester City for adults and children. Whilst benefits to the population are clearly recorded, the CCG do not consistently identify safeguarding risks to the population. In fact, risks identified are more corporate based. An example consistently included is the risk to their reputation. (**Recommendation 7.1**)

5.1.9 Multi-agency work is underway in Leicester City to address CSE. The CCG have been successful in securing funding to improve further the role of health in the multi-agency partnership and response to CSE across LLR. This will see the recruitment of a band seven and a band six nurse for an 18 month pilot undertaking a range of responsibilities including training. All young people identified as being at risk of CSE will be flagged on all systems across services. This will help to identify young people accessing services and trigger notifications to the specialist CSE nurses. Whilst this is positive progress, CSE is not an emerging issue and this response lags behind established practice we have seen in other areas.

5.1.10 The designated LAC nurse is committed to developing an effective service that contributes to improving the health outcomes of this vulnerable population. She demonstrates good leadership and is engaged in strategic decisions and developments. However, it is unusual to see the designated role which is predominantly one of strategic leadership, governance and performance management combined within a post providing the day-to-day operational management of the looked-after child nurse provision. The absence of a named nurse for looked after children in the provider setting may impact on this. In our experience the role has been predominantly within the CCG with a separate and distinct operational management post held within the provider organisation. The rationale behind the current infrastructure is not clear.

5.1.11 The intercollegiate framework for LAC (2015) sets out that one whole time equivalent designated LAC nurse should be appointed for a child population of 70,000 yet the population in Leicester City is higher than this at 79,000. Furthermore, the designated looked-after professional's role extends beyond Leicester City and includes Leicestershire and Rutland thus increasing their provision. With this in mind and given the presence of added complexities such as the local deprivation indices and the numbers of children looked after it would be appropriate to review these arrangements with consideration given to additional resources. **(Recommendation 2.17)**

5.1.12 There is no named nurse for LAC in post within the provider service. This conflicts with the guidance set out in the intercollegiate framework for LAC (2015). The absence of this role is a further deficit to resources in the team. **(Recommendation 2.17)**

5.1.13 The designated LAC professionals and specialist LAC nurses do not have complete oversight of the full cohort of children looked after which may impact on their ability to plan services. The designated nurse for LAC and specialist LAC nurses were unable to identify the under-fives and UASC caseloads for the purpose of this review. This fragmented view restricts the ability to ensure effective performance. **(Recommendation 2.8)**

5.1.14 The named GP has taken up the role very recently. He is enthusiastic to take the safeguarding agenda forward in primary care and is currently in the process of visiting practices and formulating his developmental agenda. Plans include a safeguarding leads forum and an annual primary care conference on safeguarding. The protected learning time sessions for primary care have been well attended and targeted 'deep dive' reviews into GP practices where there has been a SCR are good ways to ensure lessons are learnt and improved practice becomes embedded. Recruitment to four additional named GP sessions is in progress which will strengthen safeguarding leadership across primary care.

5.1.15 Capacity is limited for the maternity safeguarding team to undertake additional work that improves and strengthens safeguarding practice. This inhibits their ability to monitor processes and audit compliance, and their attendance at regular meetings with the network of link midwives is limited. They have good day to day oversight of active cases where safeguarding concerns have been raised through effective use of the safeguarding electronic notes system (SENS), safeguarding database and E3 IT system. **(Recommendation 3.6)**

5.1.16 Leadership and management of the health visitor workforce has been reviewed and strengthened. Particular attention has been paid to equipping the workforce and those recently qualified with the knowledge, skills and support they need to undertake complex safeguarding work.

5.1.17 The school nurse team are not fully resourced despite recruitment campaigns. There are still vacancies for band six nurses, and staff told us their caseload sizes were likely to be higher than the 1200 recommended by the Community and Public Health Visitor association and the Royal College of Nurses. Staff told us they escalate their increased activity by using the incident reporting system, but reported at the time of the review they were managing their workload.

5.1.18 The school nursing standard operating procedures is inclusive of safeguarding but the detail of what this practice entails is not explicit. This provides little clarity around the safeguarding roles and responsibilities of school nurses which may account for the varied standard of safeguarding practice we saw as part of this review. ***These concerns have been brought to the attention of public health within Leicester City Council as the commissioner for school nursing.***

5.1.19 Leicester City sexual health services are well engaged in the local multi-agency CSE arrangements, which are reported to be strengthening and developing well. The SSOTP senior nurse for the ISHS is a member of the CSE sub-group of the LSCB. The group is focused on developing and implementing the multi-agency action plan having overseen the introduction of the CSE toolkit. The group are currently engaged in reviewing feedback on its use from frontline staff.

5.1.20 Operational managerial oversight of safeguarding children practice in adult mental health was limited. Think family has not been embedded consistently in frontline practice. The adult mental health /learning disability safeguarding lead and head of nursing have taken steps to drive improvement and are developing a model called the 'whole family safeguarding approach for children'. This sets out the key children safeguarding priorities for practitioners to consider while working with the adult. These include the potential for neglect, FGM, CSE, the voice of the child and Prevent issues. ***(Recommendation 6.3)***

5.1.21 In LRP the role of enhanced family practitioner was developed to provide leadership on embedding the think family model in systems and processes, as well as in frontline practice. This is a positive approach to ensuring practitioners prioritise the safety of children in an adult service provider, and we saw a number of ways in which the role is supporting the partnership to strengthen its child safeguarding practice. These include providing bespoke safeguarding training and supervision. Practitioners in LRP told us they find these valuable and supportive of their practice development.

5.2 Governance

5.2.1 Referrals to children's services continue to be of variable quality. The improvement board are continuing to audit this and have seen some progress made. However, existing operational quality assurance processes in some services would benefit from further improvement to raise the standard. Some providers have already explored ways to quality assure referrals before they are sent into DAS to address the high volume of 'no further action' outcomes. This has identified some differences in the interpreting of the thresholds for services in different organisations.

(Recommendation 6.2) These concerns have been brought to the attention of public health within Leicester City Council.

5.2.2 Children and young people at the point of entering care continue to experience delays in having their health needs assessed. This is not acceptable. There has been a significant improvement in the timeliness of initial health assessments but there remains a lag in driving this progress further. A shared action plan is in place to facilitate a data sharing agreement. The local authority notifies the looked-after children's health team of a child coming into care within 48 hours with appropriate parental consent. This triggers the process to initiate the initial health assessment. There are challenges for the LAC health team to deliver on this as the local authority LAC team are not always able to send the notification in the agreed timescales. Progress and performance is monitored very robustly through a monthly conference call chaired by the chief nurse and attended by a senior children's social care manager for children in care and the interim director of children's services. This demonstrates the high level partnership commitment to developing an effective whole system approach. However this is not sustaining any lasting improvement.

(Recommendation 2.6)

5.2.3 The quality of health assessments for LAC are inconsistent. Designated professionals are undertaking a review IHAs regarding this issue. Minutes from meetings reflect that whilst it is an agenda item updates have been carried forward from November 2015 to February 2016. It is vital that Leicester City CCG and the provider organisation continue their positive efforts to improve the timeliness of initial health assessments, but quality must not be compromised. Cases sampled indicated there was little evidence of a benchmarked quality standard for initial and review health assessments across the 0-18 children looked after population. Existing quality assurance measures are not affecting change in raising or sustaining good standards of practice. This is an area for further development and is a requirement to comply with national standards. ***(Recommendation 2.9)***

5.2.4 The existing audit process undertaken in the LAC service is not measuring record keeping compliance for completing safeguarding information. For example cases sampled identified that safeguarding information was recorded in the journal it was not consistently being recorded on to the safeguarding node of the SystemOne record. ***(Recommendation 2.18)***

5.2.5 The quarterly safeguarding health network which includes third sector organisations is well established. This is seen by the CCG as a valuable forum in identifying areas requiring developmental work. The forum has initiated and taken forward a number of areas such as the bruising protocol and the CSE toolkit. This is a positive cross organisational approach that can strengthen partnership arrangements.

5.2.6 The designated nurses are visible in provider settings. At UHL we heard that the CCG carry out regular unannounced quality visits and these extend to seeking assurance on safeguarding practice. This proactive approach provides some oversight into on-site provider activity and progress. We have not seen the full impact of this across providers to demonstrate sustained standards of safeguarding practice.

5.2.7 There are capacity issues in the maternity safeguarding team that is further challenged by operating the service geographically across three sites. As a consequence the named midwife has very limited involvement at LSCB sub groups impacting on their involvement with strategic decision making within the locality on matters that are within their field of expertise. **(Recommendation 3.5, 3.6)**

5.2.8 The acute safeguarding team at UHL are facing an emerging risk around capacity due to imminent vacancies. This is especially pertinent as the trust has responded positively to the local authorities request that all referrals to children's social care are first screened by both safeguarding teams. This has facilitated improved quality of referrals. However, fulfilling this requirement is impacting on the capacity of an already stretched team. **(Recommendation 3.6)**

5.2.9 The UHL safeguarding team have no formal commissioned contract to access SystemOne but this is accessed to establish family links and other important information to support referrals to children's social care. Formalising arrangements to use SystemOne would ensure that this good practice is maintained. **(Recommendation 3.4)**

5.2.10 School nurses were unclear about their role when they receive notifications of children and young people attending the ED or Merlyn Vaz WIC. This may lead to variable and inequitable practice with some school nurses providing children and young people with dynamic follow up and others not. Whilst the standard operating guidance for school nurses provides a framework for clinical practice this is not robustly underpinning school nurse practice. **(Recommendation 2.21) These concerns have been brought to the attention of public health within Leicester City Council.**

5.2.11 Managers in school nursing were not able to easily identify recent referrals made by practitioners to children's social care. As a consequence this limited the opportunity to review the quality of referrals they made and indicates that managers do not have an oversight of this key part of child safeguarding practice. Furthermore, cases seen demonstrated existing operational management oversight was having variable influence at sustaining a consistent standard of child safeguarding practice. **(Recommendation 2.1) These concerns have been brought to the attention of public health within Leicester City Council.**

5.2.12 The ED do not currently use any electronic alert to identify vulnerability, including the existence of child protection plans or if a child is looked after. Such alerts can help staff to be more vigilant and aware of vulnerability in their assessment of children and young people presenting at the ED. However, every under 16 year old who attends ED is reportedly asked if they have a social worker and an 'A' form is then completed. All under 18 year olds seen in adult ED have a red sticker prompting staff to ask if they have a social worker and consider vulnerability. However, this was not present in all cases seen. Leicester local area has not yet implemented the child protection information system (CPIS). The acute trust is waiting for further updates from the national team. The implementation of CPIS would assist ED staff in identifying children protected through child protection plans. (**Recommendation 3.7**)

5.2.13 Existing operational management oversight and audit in the ED, UCC and WIC could be strengthened. Current systems have not detected gaps or variability in practice. An example of this was seen in the standard of risk assessments undertaken by staff of children and young people and of adult's in detecting hidden harm. As a consequence of weak governance opportunities to raise standards and influence child safeguarding practice are missed. (**Recommendation 1.1**)

5.2.14 In the WIC the records of walk in attendances are removed from the system after seven days. Referrals to children's social care are not held on the system therefore we could not view the quality of referrals made by practitioners. This restricts the opportunity to audit their performance to safeguard children and inhibits oversight of attendances. (**Recommendation 5.2**)

5.2.15 Operational management oversight of child safeguarding referrals made to children's social care by adult mental health practitioners is weak. As a consequence we were unable to review the quality of any recent referrals submitted. The absence of an effective data collection and monitoring system by the service means that operational managers are unable to quality assure and performance manage individual practitioners and teams child safeguarding practice effectively. This is a significant barrier to understanding child safeguarding risks and vulnerabilities in caseloads of adult mental health staff. (**Recommendation 2.15**)

5.2.16 LPT staff making referrals to the DAS and submitting reports to child protection conferences do not benefit from any consistent operational quality assurance process. For example we were told that practitioners in adult mental will often ask a manager to review a completed referral form to children's social care prior to submitting it. We could not test the impact of this as the referrals could not be identified. (**Recommendation 2.1**)

5.2.17 In adult mental health there is an absence of an effective and clear naming convention when key child protection and child in need documentation is uploaded onto the IT record keeping system. This makes it very difficult and time consuming to locate key documents. There is a risk that, for example, actions for adult mental health practitioners from child protection plans could be hidden in the record. This may delay the provision of key work identified in the child protection plan as this is not readily visible in the record. (**Recommendation 2.12**)

5.2.18 In SSOTP ISHS we saw case examples of effective safeguarding. Risks to children and young people were identified with staff making prompt and appropriate referrals to children's social care. A copy of every referral to children's social care is retained and scanned onto the case record, facilitating effective quality monitoring and ensuring a comprehensive client record. An incident form is also sent electronically to trust headquarters in Staffordshire providing good data production and oversight by the central safeguarding team. This is robust and evidences effective performance governance well.

5.2.19 The current DNA policy in use by practitioners at LRP does not support a consistent approach is used when there are children and young people linked to adult clients who miss appointments. It does not include actions that need to be carried out with regard to children, including those subject to a child in need or child protection plan. Governance arrangements including the DNA policy are being reviewed providing an opportunity to ensure that the policy and protocol is fully robust in supporting effective child safeguarding. ***(Recommendation 10.3) These concerns have been brought to the attention of public health within Leicester City Council.***

5.2.20 LRP has recently undertaken work to identify its cohort of children and young people within its caseload of adult substance misusers. Managers recognise the importance of knowing which adults they are supporting have dependent children and those children with additional vulnerabilities. This is important to ensure managers can oversee safeguarding practice effectively and strengthen operational governance of frontline practice.

5.2.21 The CCG have developed and further revised a safeguarding self-assessment toolkit for use by GPs. The document sets out expectations that GP safeguarding leads and practice managers should ensure that primary care staff are sighted and act upon the guidance provided. The tool has been updated to include 16 recommendations for GP practice arising from eight child SCR and 5 Domestic Homicide Reviews undertaken by the Leicester City and Leicestershire County and Rutland Local Safeguarding Children Board and Safeguarding Adult Board in 2014/2015.

5.2.22 A CSE toolkit developed in conjunction with the national CSE working party has gone to all GP practices. However, it is unclear how this will be embedded in frontline primary care practice. It is important to address this so all GPs in Leicester are consistently maximising opportunities to assess for risks of CSE in children and young people they have contact with to initiate early help or offer protection. ***(Recommendation 4.5)***

5.3 Training and supervision

5.3.1 Midwives are not meeting the intercollegiate guidance for their level three child safeguarding training. A UHL response indicates that midwives receive eight hours of level three safeguarding training every three years which is insufficient. As a workforce midwives are specifically identified within the intercollegiate document as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). (**Recommendation 3.9, 6.4**)

5.3.2 The named midwife at UHL is required to access a minimum of 24 hours of level four safeguarding children training. Named professionals or those with specialist safeguarding responsibilities are required to have an increased level of expertise to underpin their role as outlined in the intercollegiate document. (**Recommendation 3.8**)

5.3.3 The preceptorship programme for newly qualified midwives does not include specific safeguarding competencies. This is a missed opportunity to embed the importance of child safeguarding early in their professional career. The inclusion of safeguarding children competencies would build and develop further the standard of clinical practice that is required of midwives. (**Recommendation 3.12**)

5.3.4 Not all staff in CAMHS have received CSE training. Whilst safeguarding training in LPT provides some coverage of CSE and also FGM this is not consistently benefitting the development and awareness of frontline staff. Child safeguarding training provided to care navigators and those working in neighbourhood forums does not appear to be commensurate with the responsibilities and duties they undertake. (**Recommendation 6.4**)

5.3.5 U-learn is a learning and development system introduced by LPT last year. The system enables managers to track compliance levels of mandatory, role specific and generic training. A report is created and provided to family service managers and clinical team leaders on a monthly basis. This system is not sensitive enough to detect specific services that require further development, such as CSE within the CAMHS workforce.

5.3.6 There is variability in the induction packages offered to the 0-19 health visitor / school nurse staff and CAMHS staff in LPT. CAMHS practitioners are not provided with any enhanced safeguarding children support routinely as part of their induction or as they develop into their new role. This is offered to health visitors and school nurses and is clearly beneficial in developing their competence in safeguarding children. However, this is a missed opportunity to widen this provision to include a similar enhanced induction package for CAMHS practitioners as they too work with children and young people with additional needs and vulnerabilities. (**Recommendation 2.14**)

5.3.7 The designated LAC nurse delivers training to new health visitors on the specific needs of LAC as part of health visitor training and preceptorship. The involvement of the designated LAC nurse at this point where health staff are undertaking university courses is positive, helping to raise the profile of LAC with students embarking on a career in health visiting. In addition, there is the provision of a 15 hour per week specialist LAC health visitor who supports health visitors to undertake RHAs for children under five years. She delivers part of the training package on RHAs to the health visitors which has been made mandatory every three years.

5.3.8 Paediatric ward staff at UHL assess children and young people admitted with suicidal ideation or self-harm to determine the risk to themselves and others, however, they are doing this without any formal training. This is not compliant with NICE guidance. (**Recommendation 3.10**)

5.3.9 There is inconsistency in the types of training that staff at the WIC can access, with a lack of assurance that all staff have trained to a level commensurate with their roles and responsibilities. This indicates a poor oversight of the training needs and requirements for the workforce in the WIC. As a consequence there is a risk that staff may not be discharging fully their safeguarding children responsibilities. Clinical staff working in unscheduled care settings are required to be trained to level three as set out in the intercollegiate document. (**Recommendation 6.4**)

5.3.10 Frontline adult mental health practitioners are trained to variable levels for child safeguarding. We were told that practitioners are trained to level two as a minimum with senior practitioners and clinicians trained to level three. Case evidence and discussion with managers and practitioners strongly demonstrated that practitioners in the adult services are routinely working with cases requiring level three competencies. (**Recommendation 6.4**)

5.3.11 Adult mental health services and CAMHS demonstrated that staff at times under-utilised the expertise and support available to them by the LPT safeguarding team. Harnessing this support aids practitioners to manage safeguarding cases that can have added complexities and supports best practice. However, staff we spoke to value the support from safeguarding teams in UHL and LPT. (**Recommendation 2.5**)

5.3.12 There are insufficient numbers of LRP frontline practitioners undertaking safeguarding training at level three. Level two child safeguarding training may not equip frontline practitioners working with complex cases to detect emerging or ongoing child safeguarding concerns or support them in discharging their safeguarding responsibilities. (**Recommendation 6.4**) ***These concerns have been brought to the attention of public health within Leicester City Council.***

5.3.13 Data supplied by the CCG demonstrated that in 2014-2015 the named doctor delivered 15 training sessions to 345 GPs. The post course evaluation asks eight questions regarding varied child safeguarding issues including domestic violence giving the responder a number of responses to choose. This helps to identify areas for further development. In the practices we visited the GPs had undertaken their level three training in safeguarding children and accessed relevant additional training sessions. Compliance with training is monitored in both practices.

5.3.14 The safeguarding supervision policy in maternity is not yet embedded into practice. Whilst there are no national standards, caseload holding midwives at LRI would benefit from in depth one-to-one supervision sessions and non-caseload holders from group supervision sessions. The inclusion of one to one safeguarding supervision facilitates a degree of professional challenge for practitioners. This is essential in cases where increased support or intervention of vulnerable women is identified and that potential risk or drift is not overlooked. Group supervision sessions allow a degree of peer support and learning, particularly for staff involved in complex cases on a short term basis. Professional record keeping standards would require that when a patient is discussed a record of the safeguarding supervision along with any action plans should be recorded in the patient's notes.
(Recommendation 3.14)

5.3.15 Safeguarding supervision is not well established between the named doctor and designated doctor. The named doctor has proactively approached the designated doctor to formally request supervision and they are in the process of arranging to meet. Practitioners working in the UHL safeguarding team access group and individual supervision. The named nurse has regular supervision from the designated nurse. **(Recommendation 3.15)**

5.3.16 In the ED the model of safeguarding supervision is more informal and reactive in nature. Whilst this appears to be sufficient we have heard from practitioners in acute settings in other areas about the benefits to their practice and learning with the additional offer of more structured, formal approach to child safeguarding supervision.

5.3.17 The safeguarding supervision model used in health visiting, school nursing and CAMHS is peer related using action learning sets, but operational managers in CAMH's were unclear about its delivery. Experienced practitioners have been identified in health visiting and school nursing to lead peer supervision and have received training to underpin this. We heard that staff undertaking supervision roles in CAMHS and adult mental health have not all received enhanced child safeguarding training. Safeguarding supervisors are required to have greater expertise and require training to level four as per intercollegiate guidance. There is a risk that vulnerable cases discussed may not receive the same standard of critical analysis and discussion, with the identification of clear actions that keep the child or young person safe. **(Recommendation 2.13)**

5.3.18 Practitioners in LPT were not consistently recording safeguarding supervision or case discussions with safeguarding advisors. This does not meet professional record keeping standards. In school nursing and CAMHS we saw cases where the practitioner had recorded their intent to have a discussion with safeguarding advisors but there was no evidence that this had been completed. However, we did see evidence in other case records that the safeguarding advisors themselves make direct entries in the SystmOne record to reflect their involvement in the case. ***(Recommendation 2.5) These concerns have been brought to the attention of public health within Leicester City Council.***

5.3.19 The WIC does not have any paediatric registered nurses. To mitigate this staff have undertaken paediatric competency training and paediatric intermediate life support. There are clear processes for child safeguarding concerns. Staff stated they valued their access to telephone advice and support to aid safeguarding practice. They also have access to a dedicated line to a paediatric registrar at LRI to discuss cases of concern.

5.3.20 In SSOTP child safeguarding supervision is not a mandatory field in supervision meetings. The offer of one to one, regular planned and recorded supervision is in line with best practice, but the format and structure is not fixed and as a consequence of this flexible approach there is a risk that child safeguarding supervision could be omitted. The inclusion of child safeguarding supervision routinely will help secure a stronger focus and contribute to continuous practice improvement and performance. ***(Recommendation 11.1) These concerns have been brought to the attention of public health within Leicester City Council.***

5.3.21 In LRP not all practitioners are benefitting from the full range of supervision forums on offer in the service. The enhanced family practitioner provides fortnightly group safeguarding supervision to which practitioners can bring individual cases for reflective discussion based on the 'signs of safety' approach. Practitioners are encouraged to book one to one supervision with the enhanced family practitioner in addition to seeking unplanned advice and guidance. However, the opportunity for one to one supervision is under-utilised by frontline staff. Strengthening staff requirements to access and engage with one to one supervision will enhance their safeguarding practice and expertise. ***(Recommendation 10.4) These concerns have been brought to the attention of public health within Leicester City Council.***

Recommendations

1. Leicester City CCG, University Hospitals Leicester, SSAFA should:

- 1.1 Develop standardised benchmarked prompts and trigger questions to support effective practice in the assessment of child safeguarding risks including the potential for hidden harm in adult's attending and CSE in the emergency department, UCC and WIC. Compliance with this should be audited to ensure this is embedded and informing decisions made by frontline staff.
- 1.2 Review and strengthen the notification process of paediatric emergency department, WIC, and UCC attendances that are sent to GPs, health visitors and school nurses. Notifications must contain sufficient information to facilitate optimum decision making on follow-up actions necessary to safeguard children post discharge.

2. Leicester City CCG and Leicester Partnership Trust should:

- 2.1 Strengthen operational quality assurance and governance processes in adult mental health, school nursing and CAMHS to improve the quality of referrals to children's social care and the standard of record keeping. Performance will need to be audited to ensure standards are met and sustained.
- 2.2 Ensure staff are fully engaged with child protection plans utilising this to develop individualised care plans that are child centred and inclusive of the safeguarding responsibility of the service.
- 2.3 Ensure that the DNA policies across LPT, particularly in adult mental health, considers risks to children and safeguarding including whether children are subject to child in need or child protection plans. This would help to promote the think family approach in assessing risk and actions taken by practitioners when adult's linked with children DNA appointments.
- 2.4 Ensure that adult mental health relapse indicators and crisis plans are of good quality and are routinely shared with other professionals to facilitate early recognition of deteriorating parental mental health and a response that safeguards children and young people effectively.
- 2.5 Ensure that practitioners access safeguarding advice and supervision recording decisions and actions to ensure records are complete and compliant with professional standards.

- 2.6 Ensure continued and sustained improvement for children and young people in care to have their health needs assessed within the national timescales. This is vital to address and respond to any unmet or ongoing health needs and to improving the outcomes of children looked after.
- 2.7 Ensure resources are strengthened in the LAC team with staff deployed to address the backlog of children waiting to receive their leaving health care summaries.
- 2.8 Ensure systems are improved to enable the LAC team to maintain a complete oversight of the cohort of children looked after in Leicester and those placed out of area.
- 2.9 Ensure the quality of IHAs and RHAs adheres to best practice guidance, creating SMART health plans co-produced with children, young people and carers. Achievement of this must be audited to ensure good practice standards are achieved and maintained.
- 2.10 Ensure carers receive support and training to manage the health needs of the children looked after they care for.
- 2.11 Facilitate GP contribution in LAC health assessments as holders of the child's complete health record. This will strengthen partnership to improve the health outcomes of children looked after and will ensure GPs continue to have an oversight of their needs.
- 2.12 Develop recognisable naming conventions for use in adult mental health that support staff to easily identify and locate child safeguarding information, documents and reports.
- 2.13 Ensure that staff undertaking the role of supervisor for safeguarding supervision in both adult and children's services has received enhanced training of at least level four, in line with the intercollegiate document.
- 2.14 Develop induction packages that support new staff to develop the required competencies to safeguard children and young people effectively.
- 2.15 Develop systems in adult mental health to aid the identification of child safeguarding referrals made to children's social care, enabling effective operational oversight and governance
- 2.16 Improve access to CAMHS support for children and young people experiencing delays for assessment and interventions to avoid the inappropriate ongoing support that is being provided by primary care and universal children's services.

- 2.17 Utilise the expertise of the designated LAC nurse more effectively to enable her to discharge her strategic responsibilities and support the commissioning of services for children looked-after by recruiting a named nurse in the provider service to fulfil the requirements of the intercollegiate document.
- 2.18 Include the audit of safeguarding information in the records of children looked after to ensure this information is appropriately recorded thereby increasing the visibility of escalating and de-escalating concerns.
- 2.19 Develop arrangements for more effective information sharing from partners such as the Police and children's social care to health visitors and school nurses regarding domestic abuse incidents where children are linked to the adults involved. This will enable health staff to follow up these families and children that otherwise may not have given cause for concern.
- 2.20 Ensure health staff are pro-active in following up referrals made to children's social care to help inform their ongoing care planning of children and young people.
- 2.21 Ensure school nurses are aware of the procedures to review children and young people following their attendance at the ED or Merlyn Vaz MIU to reduce the risk of variable practice.

3. Leicester City CCG and University Hospitals Leicester should:

- 3.1 Ensure that record keeping systems in maternity enable staff to have access to a complete record that contain child protection reports, information and plans. This will ensure midwives are well informed of escalating or de-escalating safeguarding concerns for people in their care.
- 3.2 Ensure that the inappropriately delayed discharge of medically fit mothers and their babies secondary to decisions driven by the local authority are avoided. When this occurs or can be predicted this should be escalated through the safeguarding team and the trust to trigger an appropriate response.
- 3.3 Ensure environmental safety assessments are completed in paediatric areas as per NICE guidance.
- 3.4 Ensure that the UHL safeguarding team continue to have access to record keeping systems such as SystemOne.
- 3.5 Increase the allocation of resources in the maternity safeguarding team to facilitate a greater strategic contribution and influence in forums such as LSCB sub groups.

- 3.6 Ensure sufficient capacity in the maternity and acute safeguarding teams to fulfil their role and enable a stronger role in governance to quality assure the safeguarding practice of staff.
- 3.7 Develop effective flagging systems in the emergency department to alert staff when children are the subject of child protection plans, child in need or looked after.
- 3.8 Ensure that the named midwife completes at least 24 hours of training every three years as per intercollegiate document.
- 3.9 Ensure that midwives receive 12 -15 hours every three years of inter and multi-agency safeguarding children training at level three, in line with the intercollegiate document with effective oversight of compliance and competence.
- 3.10 Ensure that paediatric staff caring for children and young people with mental health problems are trained and competent to meet those needs as per NICE guidance.
- 3.11 Ensure midwives are trained to use the FGM risk assessment tool and this is embedded in frontline practice. This will help midwives to consistently assess the risk of FGM for the unborn, new-born and also other females aged under 18 in the household.
- 3.12 Include safeguarding and looked after child competencies into the preceptorship package for newly qualified midwives.
- 3.13 Ensure that midwives take a stronger proactive approach to provide women with opportunities to disclose domestic abuse or other sensitive issues throughout their episode of care and provide appointments when they are seen alone.
- 3.14 Develop and embed in practice robust safeguarding supervision procedures for midwives in line with good practice. This will support midwives to analyse, reflect and strengthen their safeguarding practice and enabling their further development.
- 3.15 Support the named doctor to access safeguarding supervision from the designated doctor.
- 3.16 Improve communication to support the routine sharing of information of domestic abuse incidents involving women who are pregnant or have a new-born baby. This will ensure that midwives are informed facilitating enhanced care and support that will help to safeguard those they care for.

4. Leicester City CCG and NHS England should:

- 4.1 Ensure GPs are professionally curious and give adequate consideration to child safeguarding when notifications of the attendance of children and young people at the emergency department, minor injuries unit and UCC are received, in particular including those attending different services on multiple occasions.
- 4.2 Ensure that prompts are developed in practices to support staff to enquire about the involvement of social workers for those registering as temporary patients to facilitate information sharing and appropriate flagging of records. This will help to make the child visible to primary care staff and enhance partnership working.
- 4.3 Ensure primary care staff routinely record the full name and relationship of any adult accompanying children and young people to help establish parental responsibility and any concerning involvement with other adults.
- 4.4 Promote greater involvement and engagement of GPs in LAC health assessments. This will strengthen partnership to improve the health outcomes of children looked after and will ensure GPs continue to have an oversight of their needs.
- 4.5 Ensure primary care staff are trained to use the CSE toolkit and that this is embedded into their assessments of children and young people.
- 4.6 Endeavour to make available a designated place of safety for children and young people in Leicester.

5. Leicester City CCG and SSAFA should:

- 5.1 Ensure resources in the WIC are available to facilitate the review of all attendances of children and young people. This will help to strengthen their child safeguarding practice.
- 5.2 Strengthen governance arrangements in the WIC to ensure that child safeguarding record keeping for walk in patients is accessible and is subject to audit to improve and sustain the standard of record keeping.

6. Leicester City CCG, NHS England, University of Leicester Hospitals, Leicestershire Partnership Trust, Leicester Recovery Partnership and SSAFA should:

- 6.1 Ensure that staff are aware and compliant with their responsibilities to share appropriate information and fulfil statutory requirements to safeguard children and young people.

- 6.2 Ensure that governance arrangements consistently raise the standard and quality of referrals made to children's social care.
- 6.3 Ensure a robust approach is developed to embed the 'think family' model through assessment, interventions and care planning processes. This increases the visibility of children and young people ensuring their needs and any risks can be considered with the adult.
- 6.4 Ensure staff are trained, and competence is commensurate with their roles in child and adult services, as per intercollegiate document in child safeguarding.

7. Leicester City CCG should:

- 7.1 Consistently demonstrate a continued population centred approach to assessing and responding to safeguarding risks identified in Leicester City.

8. Leicester City CCG, LPT, SSAFA should:

- 8.1 Improve access to the crisis mental health team to avoid delays in accessing specialist support for children and young people presenting at the WIC with mental health difficulties. This will help to ensure the needs of children and young people are being met appropriately.

9. Leicester City CCG, NHS England, University of Leicester Hospitals

- 9.1 Ensure that midwives notify GPs when women become pregnant and that information sharing is in place of the adult's record. This joint working will help to safeguard the unborn.

10. Leicester Recovery Partnership should:

- 10.1 Improve liaison with community services such as health visiting and school nursing to ensure information is shared about adults accessing their services that are linked to or have child caring responsibilities. This will facilitate a more robust joined up approach that can respond to any emerging concerns.
- 10.2 Ensure staff are engaged effectively in child safeguarding practice to include analysis of the adult's substance misuse on children, referrals to children's social care and their involvement in appropriate strategy discussions.
- 10.3 Ensure governance arrangements are robust and raise the standard of child safeguarding practice to include the development and improvement of existing procedures such as the DNA policy and the use of flagging systems to reflect escalating or de-escalating child safeguarding concerns.

10.4 Ensure child safeguarding supervision is offered routinely and is embedded in practice with decisions and actions recorded in the client records.

11. Staffordshire and Stoke on Trent NHS Partnership Trust should:

11.1 Ensure child safeguarding supervision is offered routinely and is embedded in practice with decisions and actions recorded in the client records.

Next steps

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

Please submit your action plan to CQC through The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.