

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

## Children Looked After and Safeguarding The role of health services in Staffordshire

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<b>Provider services included:</b>	Staffordshire & Stoke-on-Trent NHS Partnership Trust (SSOTP) Birmingham Community NHS Trust (BCT) North Staffordshire Combined Healthcare NHS Trust (NSCHT) South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT) Burton Hospitals NHS Foundation Trust (BHFT ) University Hospitals of North Midlands NHS Trust (UHNM) Addiction and Dependency Solutions (ADS)
<b>CCGs included:</b>	North Staffordshire CCG South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG Stafford & Surrounds CCG Cannock Chase CCG
<b>NHS England area:</b>	Midlands and East Region
<b>CQC region:</b>	Central
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## Summary of the review

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

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

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## About the review

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

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

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 140 children and young people.

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## Context of the review

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*North Staffordshire CCG comprises 33 GP Practices and 136 GPs, serving a population of 213,000 across the main districts of Newcastle-under-Lyme and the Staffordshire Moorlands. It comprises a mixture of sparsely populated rural areas (mainly in the Staffordshire Moorlands) and more densely populated urban areas (in Newcastle-under-Lyme). The geographical area includes many deprived neighbourhoods, which border on Staffordshire's most affluent neighbourhoods, highlighting large gaps in life expectancy and health inequalities.*

*Cannock Chase CCG comprises 26 GP practices and serves a population of 132,000 within the boundaries of Cannock Chase District Council (including Cannock, Rugeley and Heath Hayes) and the Huntington, Great Wyrley and Cheslyn Hay wards of South Staffordshire District Council.*

*East Staffordshire CCG comprises 19 member GP practices serving a population of nearly 123,000 across an area which includes Uttoxeter, Burton on Trent and Tutbury.*

*Stafford and Surrounds CCG comprises 14 GP practices and serves a population of 146,700 within the boundaries of Stafford Borough Council and the Brewood and Penkridge areas of South Staffordshire District Council.*

South East Staffordshire and Seisdon Peninsula (SES&S) has 30 member GP practices encompassing Tamworth, Litchfield and Seisdon and acts as the Lead CCG for safeguarding children and adults across the partnership of the four CCGs in the South Staffordshire area.

<b>Clinical Commissioning Group</b>	<b>Residents (#)</b>	<b>Residents (%)</b>
NHS South East Staffs and Seisdon Peninsula CCG	202,908	23.5%
NHS North Staffordshire CCG	202,735	23.5%
NHS Stafford and Surrounds CCG	143,722	16.6%
NHS Cannock Chase CCG	131,040	15.2%
NHS East Staffordshire CCG	122,824	14.2%

All CCGs are represented on the Staffordshire Safeguarding Children Board (LSCB); The Chief Nurse/ Director of Quality and Safety and Designated Nurse for Safeguarding represent the 4 South CCGs and The Director of Nursing and the Designated Nurse in the North represent Stoke and North Staffordshire CCGs.

Children and young people under the age of 20 years make up 22.0% of the population of Staffordshire.

The health and wellbeing of children in Staffordshire is generally better than the England average. Staffordshire was better than the England average for 12 of the 32 ChiMat indicators (37.5%); this included MMR vaccination for one dose (2 years) 94.9% compared to England average of 92.3% and Dtap / IPV / Hib vaccination (2 years) at 98.1% compared to the England average of 95.7%. Infant and child mortality rates are similar to the England average. Staffordshire was worse than the England average for five of the 32 ChiMat indicators (15.6%); this included children in care immunisations at 70.8% compared to the England average of 87.8% and hospital admissions as a result of self-harm (10-24 years) at 431.8 per 100,000 compared to the England average of 398.8 per 100,000.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Staffordshire as in other local authority areas nationally. The average SDQ scores for Staffordshire and England have remained relatively consistent in the last three years. The breakdown of scores for Staffordshire in 2015 show that a high proportion of children are “cause for concern” (41%), which is higher than the England average (37%).

The Department for Education reported that Staffordshire had 685 looked after children that had been continuously looked after for at least 12 months as at 31 March 2015 (excluding those children in respite care). As at 31 March 2015, Staffordshire had 85 children aged five or younger who had been looked after for at least 12 months. The last annual report published by Staffordshire Safeguarding Children Board was for 2014/15. The report stated that the rate of looked after children had fallen to 55 per 10,000 from 56 the previous year (932 in 2014/15 compared to 952 in 2013/14). This was lower than the national rate of 60. During the year there were 335 children starting to be looked after compared to 365 in 2013/14. At the time of this review, Staffordshire had 982 looked after children and young people (April 2016).

*Commissioning and planning of most health services for children in North Staffordshire are carried out by North Staffordshire Clinical Commissioning Group (NSCCG). Commissioning and planning of most health services for children in South Staffordshire are carried out by South East Staffordshire & Seisdon Peninsula CCG, East Staffordshire CCG, Stafford and Surrounds CCG and Cannock Chase CCG. Additional commissioners of providers are Public Health and the Local Authority.*

*Commissioning arrangements for looked-after children's health are the responsibility of the CCGs. The designated nurses are employed by the North Staffordshire CCG and South East Staffordshire & Seisdon Peninsula CCG with the designated nurse (South Staffs) being new into post in January 2016. The looked-after children's health team, and operational looked-after children's nurse/s, are provided by Staffordshire & Stoke-on-Trent NHS Partnership Trust (SSOTP).*

*Acute hospital services are provided by;*  
*County Hospital, Stafford, University Hospitals of North Midlands NHS Trust (UHNM)*  
*Burton Hospitals NHS Foundation Trust (BHFT) at Queens Hospital, Burton On Trent*  
*Royal Stoke University Hospital (UHNM) - not included in this CLAS review*  
*Walsall Healthcare NHS Trust – not included in this CLAS review*  
*Royal Wolverhampton Trust – not included in this CLAS review*  
*Heart of England Foundation Trust – not included in this CLAS review*  
*Derby Teaching Hospital – not included in this CLAS review*  
*Dudley Group of Hospitals Foundation Trust – not included in this CLAS review*  
*Community hospitals Samuel Johnson Hospital and Sir Robert Peel were also not included in this CLAS review.*

*We visited Burton Hospitals NHS Foundation Trust minor injury units (MIUs) at Lichfield and Tamworth.*

*Health visitor and Family Nurse Partnership services for North Staffordshire are commissioned by Stoke on Trent City Council (SOTCC) and provided by Staffordshire and Stoke NHS Partnership Trust (SSOTP). Responsibility for the commissioning of health visiting transferred from NHS England to SOTCC in October 2015. Commissioning responsibility for the existing Family Nurse Partnership programmes in the North of the county also transferred to Public Health in Stoke on Trent City Council.*

*Health visitor and Family Nurse Partnership services are commissioned for South Staffordshire by Staffordshire County Council (SCC) and provided by Staffordshire and Stoke NHS Partnership Trust (SSOTP). Responsibility for the commissioning of health visiting transferred from NHS England to SCC in October 2015. Commissioning responsibility for the existing Family Nurse Partnership programmes (commissioned in some districts only) also transferred to Public Health in Staffordshire County Council.*

*School nurse services are commissioned by Public Health, SCC and provided by Birmingham Community NHS Trust.*

*An integrated commissioning approach has been adopted in Staffordshire with SCC acting as the lead commissioner on behalf of CCGs for special school nursing, review health assessments for school aged looked-after children and enuresis provision.*

*Contraception and sexual health services (CASH) are commissioned by Stoke on Trent City Council for North Staffordshire and by SCC for South Staffordshire and are provided by Staffordshire and Stoke on Trent NHS Partnership Trust. The provider delivers integrated contraceptive and sexual health (CASH) and GUM (Genito-Urinary Medicine) services. GUM services are also commissioned by SCC and provided by Burton Hospitals NHS Foundation Trust in East Staffordshire; and by South Staffordshire and Shropshire Healthcare NHS Foundation Trust for South West Staffordshire.*

*Termination of Pregnancy is provided by the British Pregnancy Advisory Service (BPAS). Lead commissioner is Stafford and Surrounds CCG.*

*Child substance misuse services are commissioned by SCC and provided by CRI (Tier 3).*

*Adult substance misuse services are commissioned by Staffordshire County Council. Inpatient services are provided by North Staffordshire Combined Healthcare NHS Trust (NSCHT), with input from Brighter Futures. Community services are a collaboration between five agencies, known collectively as One Recovery. This is led by a third sector provider Addiction and Dependency Solutions (ADS), with North Staffordshire Combined Healthcare NHS Trust (NSCHT) providing the clinical input.*

*Child and adolescent mental health services (CAMHS) are provided by South Staffordshire & Shropshire Healthcare NHS Foundation Trust in South Staffordshire. Adult mental health services in South Staffordshire are provided by South Staffordshire & Shropshire Healthcare NHS Foundation Trust. The trust provides a specialist perinatal mental health service. The Brockington Mother and Baby Unit provides specialist perinatal psychiatry. The unit is based in Stafford at St George's Hospital. It is an eight bedded unit designed to accommodate mothers with their babies up to one year of age. A flat is situated on the unit, which can accommodate families and is useful as a pre-discharge assessment. There is a crèche on the unit, which is used by visiting children to play in and for individual work and for care of inpatient infants when the mother attends therapy.*

*Specialist in patient Tier 4 CAMHS services are provided by Huntercombe Hospital in Stafford.*

*In North Staffordshire, Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by North Staffordshire Combined Healthcare NHS Trust (NSCHT). NSCHT also provides perinatal day services seven days a week and has access to beds at Brockington Unit in Stafford, these services share the same consultant.*



*An Integrated Ofsted/CQC Inspection of Safeguarding and looked after children's services (SLAC) in North Staffordshire took place in June and July 2009 and a joint report was published in September 2009. This was an early SLAC with no separate health judgements.*

*An Integrated Ofsted/CQC Inspection of Safeguarding and looked after children's services (SLAC) in South Staffordshire took place in June and July 2009 and a joint report was published in October 2009. Again, this was an early SLAC, before separate health judgements were introduced.*

*Recommendations made in these inspections were not addressed separately for this review due to the intervening time since these inspections and these areas being encompassed within the CLAS review programme's lines of enquiry.*

*Ofsted carried out an inspection of services for children in need of help and protection; children looked after and care leavers in January and February 2014 and found performance to be good across the main outcome areas; children who need help and protection, children looked after and achieving permanence; and leadership, management and governance. The effectiveness of the Local Safeguarding Children Board (LSCB) was found to be **good** with the report noting that "they coordinate the activity of statutory partners and have mechanisms in place to monitor the effectiveness of local arrangements".*

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## The report

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

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## What people told us

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### **We met some new parents on post-natal wards. They told us;**

*“It’s been fantastic. Our first baby was born in Bristol. The contrast is like night and day. I felt informed throughout and my wishes and needs were listened to. Where possible, the hospital would try to organise my appointments for haematology and midwifery for the same day. They talked to each other. I would recommend the maternity unit to other parents”* – new parent at Burton Hospitals NHS Foundation Trust

*“I don’t think this ward area is appropriate for my partner. We feel dumped in here. She has been left because she is mobile and not in pain like the others in this part. The delivery suite was brilliant though. Staff talked to us and treated us right. The baby saw the paediatrician over three hours ago and they said they would be right back. We’re still waiting but we don’t know if he is going to be referred to our local hospital”* – new parent at Burton Hospitals NHS Foundation Trust

### **Foster Carers told us;**

*“I feel respected, valued and listened to by LAC professionals”*

*“I can’t say a word against the LAC team; health and social care. They have been brilliant in their support over the years, especially when times are challenging”*

*“I feel valued, it is hard work but I do feel appreciated”*

*“Initial health assessments (IHA’s) and RHAs are usually carried out wherever is most convenient for the child, and are normally conducted by someone the child already knows. We feel fully involved in the assessments; we get copies of the assessment and action plan and follow these up at the 6 monthly planning meetings”*

*“Contact with the LAC team is ok. The LAC nurse is easy to contact”*

*“Support is available if you need or ask for it; otherwise you are left alone to get on with parenting the child or young person”*

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## The child's journey

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

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### 1. Early help

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- 1.1 We saw and heard evidence of positive partnership working in Staffordshire between the County Council and health partners, led by the chief nurse in the CCG, in order to strengthen the early help offer with the development of a number of targeted initiatives. This is particularly important in a local authority area where the number of looked-after children was 1,024 at the time of this inspection. Examples of these new initiatives include; The Intensive Family Service in adult substance misuse launched in April 2016 and aimed at families with children on the cusp of care and the "Breathing Space" pilot scheme. This latter is an intensive support service for vulnerable pregnant women who have had previous children removed into care. The scheme aims to ensure that, through a programme of therapeutic, practical and behavioural support, these women are in a position to parent effectively. This pilot started in December 2015 and provides a positive opportunity to improve the outcomes for women and children.
- 1.2 North Staffordshire Combined Healthcare NHS Trust (NSCHT) is working to forge stronger partnerships with local schools and children's social care to strengthen access to early help and ensure a more responsive service to young people as their mental health needs/risks to their wellbeing change. Parenting support groups are well used to help strengthen parental attachment and positive management of children's behaviours.
- 1.3 Across all services visited and in the looked-after children's health team we saw clear demonstrations that practitioners at all levels are highly committed to the young people with whom they work and are working hard to achieve good outcomes. We saw case examples illustrating staff going "the extra mile". Although this was the case in all services, this was particularly strongly demonstrated in school nursing.
- 1.4 We visited the University Hospitals of North Midlands NHS Trust's (UHNM) County Hospital's free standing birth unit in Stafford which takes low risk cases only, having had 132 deliveries since opening in January 2015. Any woman with complex social or obstetric issues delivers at Royal Stoke Hospital in Stoke on Trent, however antenatal and postnatal care may be delivered by County Hospital obstetricians and midwives dependant on risk and issues. The pathway was reported by the trust to be working well since its integration.

- 1.5 Pregnant women generally access maternity services at UHNM and Burton Hospitals NHS Foundation Trust (BHFT) through their GP practice. Although most midwifery contact is made at antenatal clinics within the community, we saw evidence that UHNM midwives will conduct home visits if appropriate where concerns have been identified. Health visitors receive a copy of all booking forms from UHNM and are similarly notified of pregnancies by BHFT midwives facilitating the mother's prompt engagement with the health visitor service.
- 1.6 The midwifery service provided by BHFT provides some flexibility to expectant women in offering different locations for appointments to promote the woman's engagement with ante-natal care. For example; if they are not able to attend the routine clinic appointment they may be offered to be seen another day at the clinic or GP surgery. The trust does not routinely offer home visiting. For first time mothers or where there are safeguarding concerns, we were told that midwives would be expected to undertake a home visit. However, compliance with this expectation is not subject to managerial oversight or regular audit to ensure that this is embedded in practice. (**Recommendation 4.1**)
- 1.7 Burton Hospital NHS Foundation Trust has clear procedures to support midwifery practice when women miss antenatal appointments. Actions taken by the midwife are underpinned by the trust's clear guidance depending on the circumstance. This may involve discussion with the community midwifery team leader, undertaking a full risk assessment or discussions with the trust's safeguarding team and referral to children's social care, First Response, or to the multi-agency safeguarding hub (MASH).
- 1.8 In both UHNM and BHFT, there are no regular meetings of midwives with GPs to discuss and share information on vulnerable families but community midwives can access GP records to view patient records and input onto the GP systems. Records did not always reflect whether this had been done. GPs hold essential information about patients' current and historical health and social issues which may impact on parenting capacity so accessing this information is an essential part of risk assessing potential harm to an unborn. Where we have seen multi-agency and/or multi-disciplinary vulnerable families meetings established in other areas, these can be highly effective in identifying vulnerabilities and safeguarding risks early and children and families then benefit from early engagement with support services.

- 1.9 Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy and the UHNM policy on domestic abuse in pregnancy is comprehensive; stating that women should be seen alone at least once during the antenatal period. The trust has a minimum expectation that women are asked about domestic violence once during pregnancy and that enquiry should be at opportunistic intervals throughout pregnancy and the post-natal period. However, in midwifery notes reviewed, we did not see evidence that pregnant women experiencing domestic violence were being identified consistently and we found that some midwives were not compliant with UHNM policy.
- 1.10 Recording whether a woman was accompanied to an appointment is also an expected part of the maternal handheld notes. However, in case records reviewed, this section was frequently left blank and evidence of routine enquiry around domestic violence issues was not consistently recorded. In antenatal appointment care plans there is no explicitly identified visit where women can expect to be seen alone. Where women are informed in the antenatal appointment care plan that on at least one visit they will be seen on their own, this reduces the reliance on professional confidence in asking an accompanying adult to leave a consultation and thereby reduces the potential for variable practice.
- 1.11 Midwives at Burton Hospital NHS Foundation Trust, Queens Hospital are expected by the head of midwifery to enquire about domestic violence throughout a woman's episode of care in line with best practice; twice antenatally and once post-natally. This is a stronger expectation than that set out in the updated trust policy which instructs midwives to ask women periodically about domestic violence, thereby not specifically meeting guidance from the royal college of midwives (RCM) that women should be asked about domestic abuse throughout their period of care. However, our review of patient records showed that not all practitioners consistently record the outcome of routine enquiry whether positive or negative and it was not clear that compliance with expectation was monitored. In both trusts' services, our findings are indicative of underdeveloped operational oversight to ensure midwifery practitioners are compliant with their trust's policy, managerial expectation and best practice on identifying risks to unborn from domestic violence. (**Recommendation 4.2 and 5.1**)
- 1.12 We found that Burton Hospital NHS Foundation Trust midwives do not routinely receive notifications from the hospital's emergency department (ED) or the minor injury units (MIUs) of attendances by expectant women, although protocols and guidance are in place. The trust has produced guidance for admissions of pregnant women via ED which follows a medical model and which is not inclusive of safeguarding risks. Midwives may not be notified of pregnant women attending the ED / MIU following incidents such as assault or domestic abuse and therefore, may not be fully informed of all pertinent information about potential risk to the unborn. (**Recommendations 4.3 and 4.4**)

- 1.13 The UHNM named midwife told us that police attendances at domestic violence incidents where pregnant women are involved are reported to maternity services via the MASH. This system when working efficiently should facilitate good multi agency information sharing to protect the unborn child. However, the Burton Hospital NHS Foundation Trust midwifery service told us that it does not routinely receive police notifications of domestic abuse incidents involving pregnant women. On exploring this issue with MASH, the lead MASH co-ordinator and Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP) head of safeguarding acknowledged that not all domestic violence notifications go out to midwives across the county due to non-commissioning of MASH for all health partners and that the pathway of notification is not fully effective. This could result in potential risks to unborns as a result of domestic violence being missed by frontline practitioners. (**Recommendation 1.6**)
- 1.14 The named midwife at UHNM reviews the minutes of all multi-agency risk assessment conferences (MARAC) where cases where domestic violence is known to be an issue within the family or household are discussed in a multi-agency forum. She attends on an ad hoc basis where the MARAC is discussing maternity cases specifically. At BHFT, one of the midwifery safeguarding team routinely attends MARAC meetings and feeds back the outcomes to staff. A case sampled at BHFT identified that a woman was discussed at MARAC. However, the outcome of this discussion and current risk assessment in relation to the pregnancy was not on the patient record. This appeared to be a result of difficulties with the trust's electronic records system as while reviewing case records inspectors found that the electronic record system prompted the user to contact the safeguarding team for this information. It was not clear why this essential information was not held on the patient record. It is important for organisations to ensure that patient records constitute a complete and comprehensive record of all relevant events and issues in line with NICE guidance. (**Recommendation 4.5**)

- 1.15 There was good liaison between midwives at County Hospital and other professionals; including social workers and some adult mental health practitioners, although the latter was not consistent. Liaison between health visiting and midwifery teams has historically been good across Staffordshire: the health visitors and family nurse partnership practitioners (FNP) we spoke with had regular meetings with midwives to discuss caseloads and vulnerable families. Case evidence we reviewed demonstrated effective liaison between midwives and health visitors for the most part. However, in one of the cases we tracked across services, whilst there was a good pre-birth plan shared by the BHFT midwife with the health visitor, the post-natal transfer document was poor. The discharge summary had a medical focus only with minimal information about the mother's significant mental health issues. The summary did not indicate that the new-born was subject to a child protection plan or that there was a planned transfer to a mother and baby unit for further assessment (see case example in looked-after child section of this report). A new midwife and health visitor communication procedure has been developed which will formalise liaison between the two agencies. This is a positive development, as it is essential that appropriate and sustainable information channels exist as part of preventative and early intervention as well as safeguarding and child protection work to ensure safe practice and continuity of care.
- 1.16 Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP) deliver the new-born hearing screening programme: the hearing screening tests allow babies who suffer from hearing loss in one or both ears to be identified early. Early identification is known to be important for the development and wellbeing of the child and also means that support and information can be provided to parents at an early stage.
- 1.17 A good range of support is available to parents through the health visiting service and families of children under five benefit from delivery of the Healthy Child programme. All families are offered an antenatal contact and receive a new birth visit, a six to eight week visit, and development reviews between nine and twelve months and again between two years three months and two years six months.
- 1.18 The national Family Nurse Partnership (FNP) programme is offered in four Staffordshire boroughs only. The programme is currently commissioned until the end of March 2017 but has been operating in the county for seven years so is well embedded. The FNP workforce and provision has expanded in recognition of the population's needs and the identified positive outcomes for young parents and their children. The FNP service evaluates highly with service users and this is a high functioning team that models good relational working which is fundamental to delivering good outcomes for clients and babies. However, it is recognised that the programme is only commissioned to serve 50% of the eligible population so that not all potentially eligible young parents in Staffordshire benefit from this support. *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the Family Nurse Partnership service.*

- 1.19 The FNP identified that teenagers do not particularly engage well with children's centres and as a result, graduates of the FNP will, in future, be able to access STEPS for their own support and also be encouraged to provide support to other young parents. STEPS has been designed and created to provide a place where young parents who have been, or are part of the FNP programme, can meet and make connections with other parents in a similar situation to themselves. This initiative has not yet been evaluated
- 1.20 Health visiting has recently changed from GP practice caseloads to geographically based caseloads. GP practices across Staffordshire have been allocated a link health visitor but it is not yet clear how liaison and information sharing between these services will evolve under the new system. In the two GP practices we visited, liaison with local health visiting and school nursing teams was well established on a case by case basis and one of the practices had recently been established meetings involving the link health visitor on a quarterly basis. It is important that vulnerable and complex families receive a co-ordinated approach to their care, and that timely information sharing is maintained in order to facilitate prompt identification and response to emerging or escalating concerns. Regular multi-disciplinary vulnerable family meeting in GP practices can be of significant benefit to ensuring effective information sharing across primary care is maintained and the establishment of these in all practices across the county is to be encouraged. (**Recommendation 8.2**)
- 1.21 Birmingham Community Healthcare NHS Foundation Trust (BCHT) became the providers of the school nursing service in September 2015. School-aged children at school entry (school reception year) in Staffordshire have their health needs assessed using a questionnaire sent to parents and are included in the national childhood measurement programme unless parents opt out. At the time of this review, no other staged contacts were in place to universally assess the health needs of the county's school-aged children and young people. This is not in line with national guidance outlined in the healthy child programme 5-19 and limits the opportunity to proactively identify health needs in the population. We understand that a year 7 questionnaire was in development at the time of the review. *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the school nurse service.*
- 1.22 In May 2015, Public Health England commissioned the SSOTP school age immunisation team to deliver the childhood flu immunisation for school year one and year two throughout Staffordshire and Stoke on Trent. Split into North and South divisions; each year, they cover approximately 550 schools in 11 weeks to deliver the flu vaccine and the team is the primary provider, within the local area, of immunisations for predominantly primary school children. Their clinical work is reinforced and well supported by lessons which they deliver into classrooms promoting the importance of immunisations.



- 1.23 The school nurses provide drop-in clinics in high schools with good uptake from children and young people reported. This helps to increase the visibility and accessibility of the school nursing service and positively promotes public health contributing to reduced rates of teenage pregnancy and chlamydia. Provision includes delivery of sexual health and contraception advice and support; supplying condoms, performing pregnancy tests, chlamydia screening.
- 1.24 In school nursing, the voice of the child was well demonstrated in some records by using speech marks for direct quotes. However this was variable and could be developed further and embedded more robustly in practice. In one case of a young person known to be at risk, good attention was paid by the school nurse in listening to the young person's own identified needs and recording that in the records using quotation marks. Furthermore the school nurse demonstrated high degrees of compassion and kindness; supplying the young person with products such as toothbrushes, toothpaste and deodorant, a birthday card (his only one) to help celebrate his birthday and a small gift.
- 1.25 Notifications of school aged children attending the ED or MIU are sent to school nurses but subsequent actions taken by individual school nurses is based on their individual professional judgements rather than to agreed criteria to underpin their decision. This may lead to variable practice and there are not robust operational monitoring arrangements in place to identify and address variations in practice. **(Recommendation 6.5)** *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the school nurse service.*
- 1.26 We visited MIUs in Tamworth and Lichfield provided by BHFT. Attendees book in at reception and describe their condition. The receptionist follows the BHFT "first contact protocol" which lists a range of 15 conditions that the receptionist is instructed to immediately inform nursing staff of if these are presented. This includes floppy baby, overdose, or any patient giving concern. All under ones are seen by a nurse on arrival to assess if they are well enough to wait in the waiting room. The majority of children are seen promptly.
- 1.27 At both MIUs staff were initially confident that children and young people sent to other centres for review/investigation are followed up to confirm they have attended. However for those children requiring an x-ray at another location outside of MIU x-ray hours, managers were less confident that those children would be followed up to see if they had their x-ray and any further treatment. A case sampled indicated that a child was referred to see the paediatrician with a head injury but there was no record to suggest that a call to the ward was made to confirm the child had attended. **(Recommendation 4.6)**

- 1.28 At Queens Hospital emergency department (ED) Children known to be vulnerable are flagged on the electronic records system by a “Special Indicators” flag, this can be expanded to see more detail such as looked-after child, Child in Need (CIN) or child protection. The hospital safeguarding lead nurse receives lists of current looked-after children, CIN or child protection cases directly from the local authority which ensures that alerts are up to date and relevant. This is a robust method of highlighting vulnerable children and young people to help inform risk assessment and timely multi-agency information sharing. Since last year, the child protection team at UHNM receive this information rather than the ED department at County Hospital. This process will be strengthened by the integration of computer systems later this year. ED staff at County Hospital demonstrated that they did make contact with the local authority on all cases we reviewed, when children and young people or their families told them about social work involvement.
- 1.29 For under 18s who attend BHFT’s Queens Hospital ED, a mandatory social risk assessment is completed at the point of triage. This comprehensive assessment includes space to record who has parental responsibility and who has accompanied the child to the department in accordance with best practice. In some patient records however, it was noted that “Mum” or “Dad” rather than full names were recorded or the space was blank. This is insufficient. Poor information recording at this early stage is a feature of serious case reviews and is particularly important in a fractured family with complex dynamics where the recording of name is as relevant as the reported relationship. (**Recommendation 4.7**)
- 1.30 All attendances of children and young people at Queens Hospital ED are routinely shared with the child’s GP and health visitor or school nurse, and there are signs in the department to let families know that this information sharing occurs. Discharge letters produced on the new information system includes full clinical details rather than a brief summary which is good practice. At Queens Hospital ED the number and details of a child/young person’s ED attendances are on the information system, however it is not clear how this informs any assessment of risk. There is no frequent attender policy or pathway for clinician’s to follow so the relevance of previous attendances is reliant upon individual practitioner’s judgement as to what weight is given to frequency of attendance and whether any review or action is needed.

- 1.31 Emergency department practitioners at Queens are not consistently recording whether an adult patient has caring responsibilities for a child and there is no prompt within adult records to remind clinicians to routinely gather this information in order to identify and safeguard the “hidden child”. This is particularly important where parents attend ED with behaviours which may negatively impact on their parenting capacity; this includes behaviours stemming from mental health problems, domestic violence and abuse of alcohol or other substances. We were advised that referrals to children’s social care are made where concerns about a parental attendance are identified, but this again, is over reliant upon individual professional curiosity and judgement. (**Recommendation 4.8**)
- 1.32 Safeguarding triage in the MIUs is not fully supported by the prompts and triggers contained within the documentation. For children; the prompts include whether the child has a health visitor or social worker and if their immunisations are up to date. The electronic record has a mandatory paediatric screen that can be expanded further to include behaviour, physical presentation and emotional state, and referred to social care. In all records seen, the name and relationship of the adult accompanying the child was recorded and who had parental responsibility which is good practice. However, with regards attendance at the MIUs by adults, discussion with practitioners and adult cases sampled, demonstrated that there is no universal enquiry made by practitioners around dependent children or childcare responsibilities. For adults attending with substance misuse or mental health problems, managers considered it custom and practice to enquire about children yet could not demonstrate that in practice this was consistently achieved. There is no protocol or mandatory prompts on the assessment documentation to guide practitioners to think about the hidden child.
- 1.33 Similarly, no child sexual exploitation (CSE) risk assessment tools were in place in the MIUs to support staff in assessing children and young people for this vulnerability. Whilst managers were confident that staff would respond appropriately they were not auditing or challenging practitioner’s performance to ensure best practice or drive continuous improvement. For example an under 16 attending for emergency hormonal contraception would be assessed according to Fraser guidelines but as this could be bypassed as it is not a mandatory field on the electronic documentation. Fraser guidelines alone are not sufficient to assess for risk of CSE and practitioners could be missing the opportunity to identify risk to ensure services intervene early and offer protection. Overall in the MIUs, we found an over-reliance on individual practitioner’s professional curiosity with regard to identifying child safeguarding risks and what actions would be taken without the support of sufficiently robust assessment tools and documentation and an absence of managerial oversight and operational governance. (**Recommendation 4.9**)

- 1.34 Young people have good access to good quality SSOTP CASH services across Staffordshire although there are no designated young people's clinics at present. Young people did tell us that the website information was difficult to find and understand, but that staff were very helpful when they came to the clinic. There is prompt response to addressing the needs of young people under 16 and IT systems facilitate access to case notes if young people present at different clinics in the area enabling practitioners to have good scrutiny of previous contact and any previously identified risks. Information sharing between CASH and GPs in relation to children and young people where there are safeguarding concerns is variable however and this needs addressing. Engagement of CASH services with the multi-agency CSE work is underdeveloped. Managers and practitioners from the CASH teams are not involved in CSE panels or forums rather a member of the trust's safeguarding team acts as a conduit for information. This method of communicating vital information in respect of children and young people potentially at risk of harm is somewhat protracted and creates a risk that information may be diluted. CASH services can also have a part to play in identifying victims or perpetrators by virtue of being part of CSE panel discussions. It would be timely for partners to evaluate whether there is sufficiently strong engagement of the CASH services in the multi-agency infrastructure. *These issues have been drawn to the attention of Public Health, Staffordshire County Council and Stoke on Trent Council as the commissioners of the CASH services.*
- 1.35 At the SSSFT GUM service, all attendees are subject to a single set of documentation using the same format; the only difference being that for attendees under the age of 18, practitioners are expected to complete a separate risk assessment sheet based upon Fraser competence and some indicators of risk. The risk assessment document promotes a "tick box" approach and does not encourage practitioners' exploration and evaluation of the presenting factors in order to robustly assess risk, mitigate harm and develop intelligence for the wider multi-agency arrangements. Practitioners were not routinely compliant with the management expectation that the additional risk assessment for under 18s will be completed. In three records of under 18s sampled, only one risk assessment had been completed: competency of young people is not being routinely considered and the likelihood of safeguarding risks to these young people being missed is increased therefore. We found a lack of professional curiosity and probing of potential safeguarding issues by practitioners. It was not clear what managerial governance or practice oversight arrangements are in place to ensure routine good practice. We did not see evidence of managers undertaking quality audits or monitoring of case records as part of operational performance management activity. (**Recommendation 3.2**) *These issues have been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the GUM service.*

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## 2. Children in need

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- 2.1 Burton Hospital NHS Foundation Trust's Queens Hospital has clear procedures to support midwifery practice when women miss antenatal appointments. Actions taken by the midwife are underpinned by the guidance depending on the circumstance. This may involve discussion with the community team leader, undertaking a full risk assessment or safeguarding discussions and referral, ensuring the practitioner is well supported in making effective safeguarding decisions.
- 2.2 At UHNM County Hospital, midwives with special interests are available to support midwifery colleagues and we saw evidence of their link practitioner role in intra and multi-agency liaison in cases where they took caseload holding responsibility. There are link midwives for perinatal mental health, substance misuse and teenage pregnancy. There are two safeguarding children link community midwives for the trust and a substance misuse link midwife and lead specialist midwife for female genital mutilation (FGM) based at Royal Stoke Hospital in Stoke on Trent. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care, likely to result in good outcomes for the newborn.
- 2.3 In the midwifery service provided by BHFT, specialist support to specific vulnerable cohorts have been developed in a different way with a specialist midwifery post for vulnerable women being created in September 2015 to whom midwives and other health staff can refer women of concern. The focus primarily is for those women with more complex mental health problems, substance misuse and domestic violence. The specialist midwife assesses all women referred but if no specialist role is identified she will discharge the woman back into the care of the community midwives. There are no joint specialist clinics offered at present for mental health or substance misuse. We were told that the specialist midwife has developed strong links with the adult mental health team. Links with the adult substance misuse team are expected to lead to the introduction of a joint clinic in the near future.

- 2.4 At UHNM County Hospital midwifery service, the risk assessment tool is integrated within the handheld maternity records although this was not always completed in the notes we reviewed. The internal unborn child protection alert forms, however, are used consistently to alert and update the named midwife of women's additional needs or vulnerabilities. The forms are reviewed and followed up by the named midwife to ensure all appropriate actions are taken and the forms are placed in maternal health records and shared with the wider midwifery team (including Royal Stoke Hospital) and other relevant departments such as the neonatal intensive care unit (NICU). There is no facility for an IT flagging system at County Hospital currently. However, we note the plans to move to a single electronic recording system across both Royal Stoke and County Hospital sites in November 2016 with plans to be paperless. Data and numbers relating to referrals to the local authority First Response are maintained by the named midwife. This data feeds into the trust's child protection team and it is included in the annual safeguarding children report; facilitating effective performance monitoring of safeguarding activity in midwifery.
- 2.5 A number of "champions" or link health visitors with specialist interests are in place including; women's refuge, breastfeeding, infection control, care of the next infant (CONI), students, Brockington mother and baby mental health unit and the parenting assessment residential unit. These "champions" act as a valuable expert resource to the wider health visitor team and there are plans to develop further champion health visitors for vulnerable women and for dental and oral health.
- 2.6 Early help and safeguarding children responsibilities are well understood by the SSOTP family nurse partnership practitioners (FNPs) and health visitors. We also saw referrals to voluntary agencies when it was identified that families needed a lower level of support. In the records seen, FNPs and health visitors are fully engaged in safeguarding and child protection processes. Transition of cases at the end of the FNP programme to the health visitor service is structured and well aligned with FNP guidance. Children and families moving areas within Staffordshire are cared for well once health visitors are informed of the transfer in. In the records seen, there were issues in some cases where health visitors had not been informed and case notes not received by the new health visitor in a timely manner. This may cause a delay in identifying vulnerabilities and ensuring ongoing engagement with the service and could be strengthened.  
**(Recommendation 7.1)** *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the health visitor service.*

- 2.7 We saw evidence of good collaborative working between the SSOTP family nurse partnership (FNP), health visitors and families/midwives/social workers/the trust's safeguarding team and other health professionals such as dieticians and speech and language therapists. We were told however that, generally, information in relation to parental mental health issues which may impact on parenting capacity is not routinely shared with FNP or the health visitor service by the adult mental health services. This can limit the support and early intervention work FNP and health visitors are able to provide to potentially vulnerable children and families. Although adult services, including adult substance misuse, gave us assurance that they share relapse indicators and contingency plans with relevant disciplines, subject to the service user's consent, we did not see evidence of this across community health and there is scope to strengthen this.  
**(Recommendation, 3.3, 7.2 and 10.1)**
- 2.8 School aged children and young people who are home schooled or young carers are not easily identifiable to the school nurse team. There is a reliance on information being shared to inform them of this but no robust process in place to ensure that this happens routinely. These children and young people are not therefore all benefitting from the offer of the healthy child programme and may have unmet health needs. Whilst BCT managers are aware and engaged with partners in seeking solutions, these gaps still remain. It is well documented nationally that these children and young people often have additional vulnerabilities and this cohort have featured in a number of high profile serious case reviews (SCRs). *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the school nurse service.*
- 2.9 We saw some case examples of MIU practitioners taking action to share information and their concerns about potential vulnerabilities of children with other professionals, although there are areas for development within the MIUs to ensure safeguarding practice is robust and consistent. MIU's are missing the opportunity to share information of pregnant women's attendance with midwives. Attendances of concern may trigger information sharing however this is not robust and not underpinned by any agreed standard.

**Case Example:** *A mother attended an MIU with her 2 year old child with ADHD with a month long history of a cough and a very poor sleep pattern for two weeks. They had seen the GP who had prescribed an inhaler but it was difficult to support the child to take the medication. They had reportedly not been able to make another appointment to see the GP hence MIU attendance.*

*The five year old sibling was also in present whilst the father (separated from the mother and living in another area) was outside in the car. The child's physical examination did not indicate a need for paediatric referral but the practitioner was sensitive to detect distress in the mother and felt that a paediatric review was indicated to meet the needs of the child who was shrieking and un co-operative at times. The health visitor was reportedly involved and provided support but it was recorded that there was no social worker.*

*The mother appeared to be isolated with little other additional support for her children. The child was referred appropriately to the paediatrician for further assessment at another site and attended for review. The MIU practitioner left two messages for the appropriate health visitor to contact her to share information of this attendance and to express her concern. The practitioner planned to discuss the case at her next clinical supervision session.*

*The assessment focused on the physical aspects of the 2 year old's health with consideration for the impact on the mother. The practitioner missed the opportunity to be fully inclusive of the sibling and did not fully consider their needs or record their name in this complex situation.*

- 2.10 We saw variable practice in the MIUs around the assessment of mental health risk in children and young people and although there is some use of the Pathos risk assessment tool to support their decision making, this is not consistent across MIU services. In one case sampled, whilst the assessment was detailed in content, analysis of the risks and the decisions made were not underpinned by the use of a risk assessment tool. Some staff at the MIUs have not received any recent mental health training. This is of concern if practitioners are undertaking mental health assessments without being fully trained and their competency in undertaking mental health assessments assured and overseen. (**Recommendation 4.10**)
- 2.11 Children and young people who attend the ED at Queens Hospital ED and do not wait for treatment are initially followed up by staff. Parents or carers are contacted by phone and depending on the perceived risk, the case can be escalated to children's social care. If risk is perceived as low, the case is highlighted for the safeguarding nurse lead in ED to follow up. All attendances, whether or not the child/young person waits for treatment, are shared with the GP, health visitor or school nurse. However, there is no formal policy or pathway to inform decision making and there is an over-reliance on individual practitioner response.



- 2.12 Children and young people who attend Queens Hospital ED following deliberate self-harm or overdose and require treatment are admitted and reviewed by the child and adolescent mental health service (CAMHS) either the same or next day. If treatment is not necessary, some children and young people are discharged home to await a CAMHS review appointment following a team decision that this is in the best interests of the child. The ED does not currently use any mental health assessment tool for children and young people to inform this decision and this is an area for development. We understand that managers in the ED plan to look at adopting the tool used in paediatrics and this would strengthen the support offered by the ED to young people in emotional distress.
- 2.13 Both the North Staffordshire Combined Healthcare Trust (NSCHT) which provides CAMHS in the North of Staffordshire and Stoke on Trent and South Staffordshire & Shropshire Foundation Trust (SSSFT) which provides CAMHS to South Staffordshire are mindful of the challenges of working effectively to support young people where services interface. Young people who require CAMHS input who present at County Hospital ED fall under the care of SSSFT CAMHS. With the closure of the paediatric ward at County Hospital recently, young people requiring in-patient treatment or an overnight stay are transferred to Royal Stoke Hospital. SSSFT practitioners will make visits to Royal Stoke three times a week and follow up if the young person is well enough to travel back home. At the same time the NSCHT service is also visiting young people at Royal Stoke Hospital, with some risk that South.Staffordshire young people may have to wait longer to be seen. In reviewing cases in the SSSFT CAMHS service, we saw case examples of psychiatrists writing clear and explicit notes to clinicians in Royal Stoke hospital emphasising the need for them to contact the appropriate CAMHS clinician in relation to individual children. This was appropriate and positive practice to mitigate the risks of any delay or lack of information sharing until lines of communication between the hospital and SSSFT CAMHS is properly embedded. Managers in the SSSFT CAMHS were very aware of the need to monitor this interface closely to ensure young people affected by the ward closure do not experience any detriment.
- 2.14 In the south of the county, young people have good access to SSSFT CAMHS. There were no waiting lists and access targets were being met. Positive progress is being made towards the development of the integrated children's service including the planned move into three locality teams. We saw case examples demonstrating child centred approaches by practitioners with the frequency of interventions tailored to meet the changing needs of the young people.

- 2.15 Performance of NSCHT in relation to timeliness of response to routine CAMHS referrals remains an area for development and is part of the trust's action improvement plan. Progress is being closely monitored by commissioners and the relevant LSCBs to ensure improvements are evidenced in line with local transformation. Timescales from referral to initial appointment generally fall within the 18 week timescale for routine referrals, but waiting times for treatment within the required timescales are challenging. There also was evidence that some young people are entering crisis as a consequence of the service's limited capacity to provide a more timely response. Actions being taken to try and mitigate risk as capacity is enhanced include parents and the young person being advised of expected timescale delays before treatment can be offered, with encouragement to re-contact if concerns are increasing. Children who remain on a waiting list are reviewed monthly with phone calls from the team to identify changes and make necessary changes to their priority status, care plans or risk assessments. The Saturday morning art therapy group, run over two days, is an example of work to promote positive relationships with young people who remain on the CAMHS waiting list.
- 2.16 We saw positive improvement to NSCHT's approach to risk assessment, safety and care planning; helping to embed a more inclusive, shared approach to goal setting and the achievement of outcomes within the CAMHS service
- 2.17 NSCHT is working to forge stronger partnerships with local schools in the North of the county and children's social care to strengthen access to early help and ensure a more responsive service to young people as their mental health needs and risks to their wellbeing change. Parenting support groups are well used to help strengthen parental attachment and positive management of children's behaviours.

**Good Practice Example:** *We heard about strong shared working on a case by case basis between North Staffordshire Combined Healthcare Trust CAMHS, South Staffordshire & Shropshire Foundation Trust adult mental health service and the adult substance misuse provider, with care taken to ensure a young person's transition to into adult services happens at an appropriate time that is right for the young person and their family.*

*Managers in CAMHS are promoting increased recognition and support for families where parental mental health is a feature which also impacts on the health and wellbeing of children. An example was given of a Child in Need case where the CAMHS medical director was working with the adult psychiatrist where one of the children in a family has mental health issues as does the parent. The CAMHS clinician and the adult psychiatrist were attending CIN meetings and working with both children in the family to promote their awareness of their mother's mental health needs and help them to cope with future relapses in mum's mental health.*

- 2.18 An enhanced eating disorder pathway has been developed and additional funding to the CAMHs service is helping to strengthen the local offer across Staffordshire. We understand that young people's access to Tier 4 in-patient care through NHS England special commissioning can be problematic in line with the national picture.
- 2.19 NSCHT demonstrates a strong Think Family approach with children clearly referenced on parental case notes on all adult mental health cases we have seen. However, in terms of inpatient risk assessment and care planning records, children were invisible. Engagement between CAMHs and AMH practitioners is good which enables a smooth transition for young people who continue to require specialist support/oversight of their wellbeing when they move into adult services.
- 2.20 There is compliance with national expectation in the provision of specialist perinatal mental health services across Staffordshire and we were able to track a case into the specialist service provided by SSSFT across South Staffordshire. This demonstrated the service was adhering well to 'Think Family' principles which were very evident in practice. During our interviews with the service managers and from our review of cases, we noted that there was a strong, child-focused culture where staff were alert to safeguarding issues. Mothers with perinatal mental health problems and their babies benefit from the Brockington specialist mother and baby unit in the south of the county. The consultant is employed by SSSFT undertaking sessions at NSCHT under a service level agreement and the unit has two beds for North Staffordshire women. Access to the mother and baby unit is good with no waiting list and mothers usually seen within two weeks. Case examples showed beneficial outcomes from this specialist support.
- 2.21 Women who are staying on the mother and baby unit take part in their care programme approach (CPA) planning and review meetings along with members of the multi-disciplinary team involved in their care. This includes midwives, community mental health nurses and health visitors. Where women are due to be discharged, either the woman's health visitor or, in their absence a health visitor manager attends the CPA discharge planning meeting. This ensures that key information about the woman's and baby's care is conveyed to those who will manage that care in the community. Information shared at these meetings includes insight into the woman's mental health and its impact on the baby although the service manager acknowledged that this could be strengthened further by formally and overtly sharing relapse indicators and contingencies with other professionals.

- 2.22 In contrast to the perinatal service, a 'Think Family' culture was not formally embedded into the practices of the community mental health teams or the crisis team of the SSSFT South Staffordshire service. We found evidence in the progress notes of cases we looked at that showed that key information about children of the patient or children they have access to was not taken account of during ongoing planning. The minutes of a child protection review conference showed that the service had been invited to the conference but had not attended and there was no record of any report having been submitted *in lieu* of attendance. Further, there was no reference to the child protection processes elsewhere in the patient's notes. The absence of any contribution by the adult mental health team showed that the staff involved had either ignored the child protection processes or had simply not identified their significance. (**Recommendation 3.4**)
- 2.23 Of greater concern was the absence of risk assessments about the impact of parental mental ill-health on children in some of the cases we looked at in the SSSFT adult mental health service for South Staffordshire. In one of the cases we were tracking across health services, we noted that a pregnant woman had been referred to the mental health team by her GP but had failed to attend her initial appointment. There was already a significant amount of recent information known about her mental health history contained in the GP's referral that emanated from other health providers elsewhere in England. Efforts were made to trace her after her failed appointment and contact was made with her with a view to following up her appointment. However, there was no further contact made or attempted until she came to notice by way of a social worker's report for a pre-birth child protection conference some three months later. It was only at that time that the first risk assessment was carried out by the mental health service and only then to a superficial standard with limited information about the risk to her unborn baby. We saw other case examples in the service indicating there is more to do to ensure child safeguarding practice in the SSSFT adult mental health service is robust. (**Recommendation 3.5**)
- 2.24 In the NSCHT adult mental health in North Staffordshire, the manager had a good grip of the standards of practice required in safeguarding children, and practice denotes a high standard of Think Family work. When people first present to adult mental health services, care is taken to ensure key details about children, their names and dates of birth and care status/parental responsibilities are clearly recorded by the access team which then feeds through into the longer term casework.
- 2.25 All care plans seen in NSCHT adult mental health provided clear reference to children and the adults' parenting responsibilities with some excellent examples of joint working with other relevant services such as; police, substance misuse, children's social care and CAMHs. High priority is given to supporting multi agency safeguarding work through practitioners' active engagement in CIN, child protection and multi-agency risk assessment conference (MARAC) related work.

- 2.26 Adult mental health practitioners in NSCHT have a good understanding of their professional accountabilities for safeguarding children including early identification of risks. This denotes required improvements in practice have been embedded following learning from a serious case review in the area.
- 2.27 Adult mental health staff in NSCHT are vigilant to the needs of young carers. We saw good recognition of the needs and risks to the emotional and mental wellbeing of young people where parental mental ill health is an issue. Both NSCHT and SSSFT adult mental health services have dedicated carer's assessors who can offer assessments of the needs of young carers.
- 2.28 The management of transition arrangements was strong on adult mental health cases seen for young people who require ongoing mental health support and people with children who transition into the area.
- 2.29 We heard in the adult substance misuse service that liaison and information sharing works well with midwives across Staffordshire and in acute hospitals in neighbouring authorities, facilitated by the presence of an adult substance misuse practitioner within the hospitals. These practitioners provide training and promote effective information sharing. The service works closely and effectively with the specialist substance misuse midwife(s).
- 2.30 We heard about a GP practice in Stafford currently working with 42 substance misuse service users in a contracted arrangement, one of two in Stafford. Across the county as a whole, there are 15 GP practices with contracted Shared Care arrangements. Adult substance misuse report good connections and effective liaison generally with GPs. The NSCHT clinical service manager is in the process of liaising with the CCG primary care teaching co-ordinator to further raise awareness of the range of support services offered across the NSCHT and One Recovery partnership.
- 2.31 Managers in the adult substance misuse service had a clear expectation that relapse indicators will be shared with health visitors and other relevant professionals with the service user's permission. This was further evidenced through our discussion with a practitioner although we were unable to review supporting evidence in case records due to the failure of the IT system during this review.
- 2.32 The Vulnerability Core Group is a police led, multi-agency forum attended by agencies including; children's social care, adult social care, Police (Chair), and community mental health teams (CMHT). This group examines cases brought to it and identifies which agencies can best provide support and how. It is effective in facilitating shared awareness and joint strategies for dealing with risks of violence/parental mental ill-health and their impact on children living within a household or local community.

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### 3. Child protection

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- 3.1 The referral pathway into children's social care (First Response) when health provider practitioners have concerns about vulnerable children or families; or to MASH for safeguarding and child protection concerns, is well embedded. Provider services have been consistent in telling us that multi-agency referral forms (MARFs) are routinely copied to trusts' safeguarding teams. Due to IT problems, which were problematic across provider services during the week of this, we were unable to review the quality of referrals in most services. At Queens ED, we were informed that the trust safeguarding lead nurse quality assures these and will feedback to ED practitioners to improve the quality of referrals where appropriate. Referrals were formally audited in the trust in July 2015 which identified areas for improvement; a re-audit is due July 2016. The new IT system should address most of the identified areas for improvement.
- 3.2 Referrals made to children's social care by midwives are too variable in quality. Referrals made to children's social care by midwives at UHNM are quality assured by the trust's safeguarding team based at Royal Stoke Hospital. We were told that issues identified from this quality assurance are; that risk and concerns are not always articulated well and forms are not always fully completed. This area for development has been fed back in safeguarding training. We reviewed a number of MARFs from UHNM and from BHFT midwives and found them to be of variable quality: the forms were not all fully completed with demographic information but also, more importantly, lacked details of household composition. One referral, made by the BHFT specialist midwife to children's social care over escalating concerns for maternal mental health and concerns around the parental relationship, was comprehensive with risk to the unborn outlined well. In several of the MARFs seen however, the information from midwives in both services was descriptive rather than a clear analysis of the risk of harm to the unborn. Professional opinion about the potential impact of the issues on a new-born in relation to the threshold document or the expected outcome of the referral was not included (**Recommendations 3.6 and 4.11**).

- 3.3 The standard of referrals made by the South Staffordshire adult mental health service was also variable. Examples being; in one referral we noted that the emotional impact on a six year old child of the mother's mental health as exacerbated by the behaviour of the estranged father was well articulated as part of the referral. However, in another case of an 11 year old boy expressing suicidal ideation, such information was not conveyed well and focused on the mother's clinical needs as opposed to the impact of her deteriorating mental health on her son. This does not best support effective decision making in children's social care First Response or the multi-agency safeguarding hub (MASH) about what level of intervention will result in the best outcome. While referral activity is monitored in the trust, frontline managers do not review referrals to ensure best quality is achieved consistently (**Recommendation 5.2**).
- 3.4 In UHNM, midwives attendance at pre-birth safeguarding meetings is expected and prioritised. A report for initial child protection case conference (ICPC) is only completed if a midwife is unable to attend. Attendance at safeguarding meetings is monitored closely by the named midwife and escalated to the team leader or head of midwifery if necessary. We saw good evidence of the outcomes of safeguarding meetings being noted in women's health records to ensure that the wider team is fully aware of the most up to date information and plan. Where required, safeguarding birth plans with clear actions identified to protect the baby were in place in both UHNM and BHFT midwifery services. In BHFT, all invitations to case conferences come to the safeguarding children matron and the named community midwife for the woman and child. Attendance of BHFT midwives at child protection case conferences and submission of written reports is monitored by the trust although case records we evaluated did not evidence this.
- 3.5 University Hospitals of North Midlands NHS Trust has a female genital mutilation policy in place and we found a robust and thorough process in place in the midwifery service to address this nationally and locally growing issue. All pregnant women are asked if they have experienced FGM and we saw this well evidenced in records. Where women disclose during pregnancy that they have been subject to FGM, a comprehensive FGM questionnaire is completed; a consultant's appointment arranged and the legal issues around FGM explained to the woman. We were told that a child protection referral is made in cases where any risk to the new-born or existing children is identified.
- 3.6 Health visitors are confident in referring to early help or children's social care as needed. They are aware of and understand the threshold document. All staff spoken to highly valued the support of their trust named nurse for safeguarding children. Relevant safeguarding and child protection reports, meeting minutes and plans were seen within health records reviewed.

**Case Example:** *An 18yr old female, had herself been on a CIN plan, had low educational attainment and was involved with the youth offending team (YOT) due to a history of her assaulting family members and members of the public. There was a long history of social care involvement with the family. There were known domestic violence issues in her relationship with her current partner who was the father of her unborn baby and significant risk factors were identified with minimal resilience factors.*

*The mother's engagement with services in pregnancy was poor. There were multiple incidents of domestic violence during the pregnancy and one postnatally and the unborn was made subject to a child protection plan. The baby's father was imprisoned for a previous assault on the mother.*

*Through the FNP, the mother was supported to understand the effects of domestic violence on babies and children and engaged well with self-esteem and confidence building work. She was also supported in understanding the baby's needs, and putting these needs ahead of her own.*

Outcomes

- *Child development assessments show baby is developing normally*
- *Relationship with abusive partner ended*
- *Mother now recognises and prioritises the baby's needs above her own*
- *Full engagement with FNP programme*
- *Mother is keen to engage with other services*

- 3.7 Practitioners spoken to across services reported that they had confidence in and used the escalation policy to resolve any professional disagreements. The escalation policy is rarely invoked in practice. However, we found prolonged stays of medically fit mothers and babies due to legal proceedings being undertaken by children's services. The management accept that this is not acceptable but alternative solutions do not appear to be available to them. This is not being escalated by using incident reporting systems to flag these events up in the trust and it is not clear how this is being addressed in children's social care. (**Recommendation 4.12**)
- 3.8 School nurses are linked to all educational settings including academies and pupil referral units. While they are not commissioned to provide services to independent schools in Staffordshire, when notified of safeguarding meetings such as child protection case conferences, school nurses will attend. The process to support their role for any further work with the children and young people is unclear however.



- 3.9 In school nursing, we saw some good examples of written reports for child protection case conference in the records we tracked and sampled. In one child protection report we read that the school nurse challenged the category for the child protection plan. This indicated that this practitioner was engaged actively and dynamically in the child protection process and able to challenge in a confident and professionally appropriate manner.
- 3.10 There is a dog bite policy in place at Burton Hospital NHS Foundation Trust, which given the number of high profile cases nationally in recent years, is a sensible and appropriate provision. However, practitioners did not have an awareness of the policy. BHFT acknowledged that this needs to become a mandatory action and be included as part of a wider policy document for ratification and sharing with the MIUs and paediatric wards (**Recommendation 4.13**).

**Case Example:** *A school nurse was reviewing the MIU attendance of a young person who had been bitten by a dog. The information on the notification from the MIU was limited and the nurse contacted the parent to assess this event further. The young person was reportedly visiting the home where three large were kept. The mother had said she was “mauled” by one of the dogs and had to escape to a room and close the door for her safety. The mother said the girl will not be visiting that home again.*

*The school nurse contacted the paediatric liaison nurse to clarify the safeguarding procedures in place at ED and MIU around dog bites. There is reported to be no such guidance in place.*

- 3.11 Both GP practices visited used an electronic patient records system that carried alerts about vulnerable children. However, in one practice this facility was not used for all children who were at risk. For example, one teenaged patient who had been notified to the practice as being at risk of CSE had not been subject of such an alert on the system. The notification that brought this to the practice’s attention, a letter from the local authority, was not immediately apparent in the record and so there was a risk that this information would not be considered if the young person presented for a consultation. The risks of CSE, the tools available to assess such risks and the local arrangements for managing CSE risks in individual children were not clearly understood in this practice. Senior staff in the practice acknowledged this was a significant gap. (**Recommendation 8.3**)

- 3.12 The use of technology such as telephone conferencing to facilitate increased GP participation in child protection case conferences has not been fully explored. This is a missed opportunity as this could be utilised to good effect in so large a county. In one of the GP practices we visited, although attendance in person was rare, information was routinely provided to child protection conferences by way of a written report. In the other practice information governance arrangements for child protection processes were not robust. For example, in one case, we saw that there had been no information sent to a child protection conference and no acknowledgement or letter of apology sent in response to an invitation that had been received in good time. We learned that this was customary in this practice unless there was any significant information to feed back to the conference. The absence of any response at all from the GP means that the chair of a child protection conference would be unaware if the GP held any information such as a GP's observations of the interaction between parent and child when visiting the surgery that would help in conference decision making. This is not good practice.
- 3.13 In another case, we learned during discussion with one of the non-clinical staff that a child who had been subject of a child protection plan had been seen locally with a parent by one of the practice staff. The circumstances of this were sufficiently worrying to warrant this information to be reported to the lead GP. However, there was no record of this encounter on the patient record system or of this information being shared with the child's social worker. This demonstrated a limited insight about why such information might be important. (**Recommendation 8.4**)

**Good Practice Example in Primary Care:** *Female aged 10 was previously on a child protection plan for risk of physical abuse from father.*

*A pop-up alert on the patient record system shows child protection risk. The record contained a clear narrative about the previous risks and showed that the child was no longer on a child protection plan.*

*The GP told us that the alert stays on the system because the family is still intact and so this will help to make GPs and practice nurses aware of the previous risks during patient consultation and ensures practitioners are extra vigilant.*

- 3.14 In one of the GP practices there was a strong safeguarding culture promoted by the lead GP. This included numerous in-house training opportunities to supplement the required training such as cascading topical information about safeguarding and case discussion during meetings. This embedded knowledge and understanding was evident in all four of the cases we sampled in the practice where record keeping was of a good standard and child protection process were followed in a timely way.

- 3.15 In the NSCHT CAMHS service in North Staffordshire, multi-disciplinary team working has been strengthened proactively as workforce capacity has been increasing with the recent additional investment in staff. As a consequence, there is now good representation by NSCHT CAMHS at child protection and CIN meetings. Case records indicated an increased vigilance among practitioners to risks of CSE and the impact on young people of parental mental ill-health, domestic violence and substance misuse.

**Case Example:** *Referral to CAMHS made by GP in January 2015; Young person with severe anxiety and socially isolated, with family history of suicide, attempted suicide and self-harm. Parent was struggling to cope.*

*Initial opt-in appointment offered in February 2015 and followed up in March. Young person was placed on waiting list for anxiety management and parent waiting for Triple P Parenting course*

*Treatment commenced September 2015. Clear aims of plan of care which included further assessment of Autistic Spectrum Disorder and mental health assessment. Mother offered Triple P parenting course.*

*The CAMHS consultant has made regular home visits with regular telephone reviews with the young person's mother in between visits and involvement in multi-agency CIN meetings as the young person's needs continued to escalate.*

*The case record denoted good standard of practice through use of a chronology to map key life events and risks*

*There was evidence of the case being discussed with the trust's safeguarding named nurse as case escalated from CIN to child protection in December 2015.*

*The consultant was unable to attend child protection conference but provided a report that provided clear and relevant information about risks to the child and of parenting capacity.*

*Although the case highlighted a lengthy delay in the first nine months of 2015 in progressing to treatment from the point of initial referral; the case demonstrated effective recognition and management of suicide risk with good multi-agency working with the young person and their parents.*

- 3.16 Across the CAMHS services work is of a good standard overall, with some excellent examples of engagement and person centred practice. However, the quality of the services in the North of the county is negatively impacted by the legacy of lengthy waiting times.

- 3.17 SSSFT CAMHs are fully engaged with child protection processes; an area for development being to ensure that appropriate flags are applied to the case record reflecting the decisions of ICPCs and child protection case conferences promptly and accurately as this was not the case in all case examples reviewed. We found some lack of clarity within the service about who was responsible for the flagging of risk. We were subsequently informed that flagging cases is undertaken by the central safeguarding team in SSSFT rather than by the case holding practitioner. This is not common practice and may present some additional challenge to the trust to ensure that the safeguarding team are promptly alerted to changes in status following case conferences (**Recommendation 3.7**).
- 3.18 Managers of the NSCHT adult mental health service reported high (99%) attendance at child protection and CIN meetings when invited. Attendance is routinely monitored by the safeguarding children nurse. If practitioners cannot attend, they will give a verbal update. It is regarded as sufficient for them to attend and provide a verbal update; but will always provide a written report when asked to do so. However, best practice would be that a written report is submitted in advance of a child protection conference in order for this to be shared with the parents and other professionals. Analysis of all case records showed high levels of involvement in child protection meetings with records of initial child protection case conferences (ICPC) and review child protection conferences providing evidence of positive recognition of the impact of poor parental mental health on children. In one case we saw exemplary practice where the case worker's record of a home visit made clear reference to the areas where parental capacity needed to be strengthened in line with the child protection plan.

**Case Example:** *The NSCHT adult mental health service are working with a mother with bi-polar disorder and substance misuse issues with school aged son and a toddler. The children are on child protection plans for emotional abuse*

*The adult mental health safety plan makes clear reference to risks to children and their child protection status recently recognised, has been flagged on the e-record system.*

*There was evidence on the case record of good liaison between adult mental health, substance misuse and health visitors and school nurses keeping each other of failed appointments. Adult professionals were appropriately engaged in multi-agency risk assessment conferences (MARAC) meetings. The local ED was also kept informed of risks.*

*The psychiatrist's report to the mother and children's GP clearly referenced the children and their child protection status*

*This case clearly demonstrated effective multi-agency working and information sharing to keep children safe.*

- 3.19 Safeguarding teams across the provider trusts routinely attend MARAC and adult mental health and adult substance misuse engagement with multi-agency public protection arrangements (MAPPA) and MARAC arrangements was reported to work well. What was less clear was whether outcomes from MARAC are robustly informing frontline practice and clearly recorded in individual case records. We saw case evidence in Queens midwifery service demonstrating this was not embedded practice. Given the challenges of information systems in transition and the fragility of some electronic systems it is likely that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is not always being well secured. This is an area of development across the local health economy for the safeguarding teams and in primary care to ensure accurate read coding and links between family members within the practice.  
**(Recommendations 2.1, 3.8, 4.14, 5.3, 6.6, 7.3, and 8.5)**
- 3.20 The adult substance misuse service, One Recovery, has a good understanding of the 'Think Family' model of service delivery ensuring that practitioners prioritise the safeguarding of children while working with the adult and the service is working on embedding think family principles. ADS documentation has recently been revised to better support effective child safeguarding practice. We heard case examples evidencing positive outcomes for children in vulnerable families as a result of intervention and support from the service. The referral pathway into children's social care when health provider practitioners have concerns about vulnerable children or families or safeguarding/child protection concerns, is clear and well understood in the substance misuse service.
- 3.21 Home visits are routinely undertaken to service users where there are known to be children aged under 5 years old in the household and to homes where there are older children on a risk assessment basis. The consideration and monitoring of safe storage of potentially harmful substances is prioritised. Adult substance misuse managers told us that liaison with adult mental health in South Staffordshire works well, facilitated by a well-established multi-disciplinary liaison meeting.
- 3.22 Substance misuse practitioners routinely are members of core group where there are service users with children subject to child protection plan. Practitioners are expected to submit written reports in advance of child protection case conferences and we were told that this is monitored through supervision. However, a case seen in CAMHS (South), showed that a substance misuse practitioner was not attending core group or child protection conferences and the CAMHS practitioner had not met them indicating the monitoring of compliance in the substance misuse service may need strengthening.

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## 4. Looked after children

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- 4.1 The looked-after child health model of service delivery was highly fragmented; potentially creating risks to children's health and wellbeing and not delivering good outcomes for this cohort. We were unable to look at any complete, single looked-after child case record for any individual child as the system and the commissioned delivery model does not provide for this. In order to ascertain a picture of how looked-after children's health needs were being identified and addressed, we had to access individual children's records within the separate health services. This is creating risks to children's health and wellbeing. The current service model is not delivering good outcomes for this highly vulnerable cohort.
- 4.2 Performance on the timeliness of IHAs and RHAs is challenging for both children's social care and health and senior managers expressed a lack of confidence in the accuracy of the data. (**Recommendation 1.1**)
- 4.3 Initial health assessments (IHAs) are undertaken by appropriately qualified clinicians but we found that the quality was highly variable. Quality ranged from unacceptable poor to very good/outstanding. There was lack of routine attention or consideration of the child's ethnic background and its potential implications for the way health support is provided. There was no effective quality assurance process in place for IHAs. Cases seen in school nursing of review health assessments demonstrated that there is no effective frontline or overall framework for quality assurance in place to ensure a consistent satisfactory standard and drive improvement. Only one RHA seen in health visitor case records was judged to be of a satisfactory quality. (**Recommendations 1.2, 3.13 and 6.1**)

**Case Example:** *In one case, the initial health assessment documentation was missing. In the record we could only locate part A of the British Association of Adoption and Fostering (BAAF) form. This had not been picked up as missing by school nurses who had at the time recently received the record noting that the initial health assessment had been completed. The absence of part B and C is a significant loss to the health record and does not identify what if any unmet health needs may need to be addressed by health agencies.*

*This was drawn to the attention of school nurse managers for immediate remedial action.*

*In another case, the paediatrician had undertaken an initial health assessment (IHA) for a young person who had been discussed at a multi-agency child sexual exploitation (CSE) panel. The health assessment demonstrated that there had been insufficient consideration of this significant and known CSE risk when assessing her health needs and the potential impact of this on her present and future health.*



- 4.4 Health visitors undertake review health assessments (RHAs) for children aged 0-5 years and school nurses undertake these for school aged children and young people. We were told that training had been provided to those practitioners two years ago. Health visitors informed us that they had not received any specific training on undertaking RHAs in recent years. In order to improve and then sustain the quality and therefore value of RHAs to looked after children, the provision of regular training for staff conducting the assessments within a rolling programme is essential. (**Recommendations 1.3 and 6.2**)

**Case Example:** *Mother and father with a female child born in this country and now aged 8 months. Baby had been subject to a child protection plan as an unborn. Both parents are asylum seekers with no recall to public funds. Mother has a diagnosis of personality disorder and schizophrenia. Mother and baby were placed in a mother and baby unit immediately after the baby was born as father did not want sole custody. Baby was then removed into care and mother has since been deported, whereabouts of father were not documented.*

*The pre-birth plan was developed within an appropriate timescale and indicated good liaison between midwifery and the health visitor.*

*Burton hospital post-natal transfer document was very poor to health visitor. It was a medicalised discharge with very minimal information about the mother's emotional health. The discharge also did not indicate the new-born was on a child protection plan or that there was a planned transfer to a mother and baby unit.*

*The child's demographic details were not complete; no parental responsibility documented, no ethnicity and no GP identified. A risk marker box was there but not completed despite the baby being on a child protection plan.*

*The health visitor record keeping was poor; consisting of A6 pieces of paper stuck onto a sheet. The records are hand written and while legible included no risk assessments, analysis or action planning. The notes indicated a good level of attendance at child protection meetings and good multi-agency liaison with the social worker and midwifery. A copy of the child protection plan was on the case record but there was no indication as to how this informed practice.*

*The RHA completed by the health visitor was medicalised, with little information about culture or parental health and attachment and the health action plan was limited and not SMART. The foster carer had signed consent. Developmental delay was identified and an appropriate referral made to the paediatrician.*

- 4.5 The child or young person's GP is not invited to contribute towards any assessment of health and information from GP's does not inform the review health assessments undertaken by school nurses or health visitors. Given, in light of our findings, that there is no single looked-after child health record for such children and young people in Staffordshire, this is a particularly impactful missed opportunity; the GP being the holder of potentially the most complete overall health information for individual children. **(Recommendations 1.4, 6.3 and 8.1)**
- 4.6 Health plans for IHAs and RHAs were not SMART and did not set out clear health objectives with monitored actions to be undertaken within a clear timescale by an identified person who could be held accountable. Health action plans seen in the school nurse service were not dynamically reviewed to ensure that actions had been taken to address identified health needs. The health plan identified at the last RHA often did not inform the next review health assessment. Review health assessments were episodic therefore and as a result there was a high risk that a child's health needs may not be properly addressed. We saw no evidence that there is an identified and accountable person to ensure health and wellbeing needs are addressed and met. For some children and young people, health actions identified may not be reviewed again by a health worker until the next annual health assessment. **(Recommendation 1.3 and 6.2)**
- 4.7 The specialist CAMHS service Sustain Plus, provided by SSSFT across the county, provides a good quality one-stop-shop service for looked-after children covering up to 25 years of age; with nurses in post to address the previously un-met health needs of looked-after children. The service works directly with Staffordshire carers and other involved professionals, and with children and young people who are looked after. They also offer a service to adoptive parents and their children and work with children and young people where there is no plan for rehabilitation to their birth families. Sustain provides therapy and consultation to help, support and maintain placements; providing direct therapeutic work with individual young people and family units.
- 4.8 While strengths and difficulties questionnaires (SDQs) are undertaken in line with national requirements and inform access to Sustain Plus, these are not currently being used to inform the child's review of health needs or enable the young person to be more actively engaged in the management and evaluation of their emotional health and wellbeing. This is a missed opportunity. **(Recommendation 1.5 and 6.4)**



- 4.9 In Sustain Plus, we saw some outstanding child focused care plans and child friendly documents; from pictorial leaflets to describe the service, to visual aids to track progress and leaflets describing care plans to children. The voice of the child was a well evidenced focus of the service. If a child self-harms and accesses ED, the appropriate CAMHS team undertakes an assessment. If the child is known to Sustain they will then take over that child's care. Sustain Plus described a good working relationship with the CAMHS services and feel that they work around each other well, to meet the needs of the child. We saw positive engagement and challenge by mainstream CAMHS practitioners (North Staffordshire) in supporting a range of interventions to help address the risky behaviour/complex needs of a young person who is looked after.
- 4.10 Sustain Plus also undertakes physical health assessments of the young person they are working with. These are sometimes shared with school nurses but are not shared with the specialist looked-after children's nurses. So, when engaged with Sustain Plus, young people in care undergo their statutory RHAs from the health visitor or school nurse, as well as Sustain Plus's own physical health assessments both of which produce a health plan which may or may not correlate but which are never linked together. The rationale for this duplication of health review activity taking place at the time of the inspection for the cohort of looked-after children with mental health needs, was hard to understand. It is likely to be highly confusing to the children involved as well as their carers. In the absence of co-ordinated and effective operational or designated nurse oversight and the absence of any framework of quality assurance; the doubling up of this activity appears to have no purpose and is not delivering improved outcomes for looked-after children (**Recommendation 3.9**).
- 4.11 While Sustain Plus practitioners share emotional health work with the child's GP and social worker they do not send it to the looked-after child nurses, health visitor or school nurse to inform the mainstream RHA. This is a common area for development that we have identified nationally, but which is very much a part of the overall picture of fragmentation of health support to looked-after children in Staffordshire.

- 4.12 We found gaps in case recording in identifying clearly that consent for IHAs and RHAs had been given. Young people who were able to do so, were not being given opportunities to sign their own consent for a health assessment to be undertaken which would encourage them to engage in managing their own health and wellbeing. More worryingly, we found there were commonly issues across the county in seeking and obtaining consent when children and young people who are looked-after require invasive treatment. We met with a group of foster parents with extensive experience of fostering children and young people over a range of ages and with various complexities; emotional/behavioural issues as well as complex physical health issues. Several of the foster carers told us of difficulties that arise when consent needs to be obtained for invasive treatment of the young person and that different hospitals within the county have different requirements. Some hospitals are happy to gain informed consent over the phone and for a children's social care service manager to sign consent and fax or send this electronically. Others require the children's social care service manager to be present to have a face to face discussion with the clinical team and to sign consent on the day of the procedure. This causes unnecessary confusion at a time of high anxiety and can lead to a delay in procedure for some children/young people. We heard one case example where this had happened. These issues were not being picked up through the specialist looked-after child nurse or the designated looked-after child nurses.  
**(Recommendation 9.1)**
- 4.13 The foster carers we met all felt they had excellent access to training and could attend LSCB professional multi-agency training, bespoke sessions on a range of relevant subjects as well as a portfolio of e-learning packages. Training is adapted to meet the needs of foster carers with evening and weekend courses being facilitated and foster carers can identify specific training needs which are generally met. One foster carer said, "Staffordshire are brilliant for access to training". Foster carers are expected to attend a minimum of 21 hours training per year. All foster carers felt that considerable consideration is given to placing children and young people with foster carers who have the skills to meet their needs. This has improved over the last few years and the carers felt that this has resulted in greater stability and better outcomes for the young people.
- 4.14 We met with care leavers and heard a range of views and experiences of their time in care. Although some young people told us they had not received one, we noted that Staffordshire had developed health passports to be provided to care leavers and this is positive.

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# Management

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

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## 5.1 Leadership and management

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- 5.1.1 Partnerships are making progress in drawing services together county wide in a historically challenging community and multi-agency landscape. We note that the child sexual exploitation (CSE) strategy remains interim, where we are commonly seeing partnerships implementing agreed multi-agency CSE plans nationally. There is significantly more to do to ensure a comprehensive and well-co-ordinated approach to the management of CSE within health and across the wider partnerships.
- 5.1.2 A memorandum of understanding has been agreed between the Cannock Chase CCG, acting on behalf of the Southern Staffordshire CCGs, and Staffordshire Public Health to formalise the principles of joint working. Both the CCG and Staffordshire Public Health will be held to account for delivery as a CCG and through the Staffordshire Health and Wellbeing Board. Integrated working with Cannock Chase Council and Staffordshire County Council has also been strengthened, building on the plans for integrated commissioning that were signed off by the Staffordshire Health and Wellbeing Board in 2015. Partnership working with the local authorities has been further enhanced by an office move, which now sees the CCG based within the county council headquarters in Stafford and with a large office at Cannock Chase Council. The CCG reports that the relocation has not only supported collaborative working in areas such as the Better Care Fund, but has also identified new opportunities for joint working around communicating and engaging with the public.
- 5.1.3 Integrated commissioning arrangements are being implemented for mental health; with the health and wellbeing board endorsing the mental health strategy and integrated commissioning arrangements are now being designed. For drugs and alcohol commissioning; the alcohol and drugs executive board is established and implementing an integrated commissioning plan. It now reports to the health and wellbeing board annually on progress. In regards to children's commissioning; the board endorsed the strategy for children and young people. To develop health and wellbeing at a local level, the board endorsed the report achieving strategic outcomes through locality-based delivery and the strategic locality leads group is now operational and leading on integrated commissioning locally.

- 5.1.4 The well-established combined children and adult's MASH (multi agency safeguarding hub) operates well and includes representation from a range of agencies including; police, probation, children's and adult social care, SSOPT and both adult mental health services. MARAC are part of these arrangements. The MASH has developed a single point of coordination of all referrals including referrals in respect of children and young people at risk of CSE and receives around 46,000 referrals or contacts in a year. Of these, around 20,000 were subject to information sharing between partners in order to reach a conclusion about the action to take. There is increased demand with 19,456 information sharing events in 2014/15 compared to 13,500 in 2013/14. Currently, there is not facility for the MASH to have a portal into the acute hospitals' information system and information is gathered through health visitors who are able to access records and act as a conduit for information back into the MASH.
- 5.1.5 The four SSOTP named nurses from the safeguarding team and cohort of lateral checkers (administrative) provide high quality, efficient and effective support to the MASH. This is not commissioned by the CCGs. There is always one named nurse present in the MASH. However, this does stretch capacity of the safeguarding team in undertaking their wider responsibilities in providing leadership, governance and support to frontline staff in a very large provider trust with acknowledged areas for development and it is difficult to see how sustainable this is for the future. We identified the need to strengthen safeguarding supervision and operational governance of frontline safeguarding practice and the safeguarding team have a key role in ensuring these arrangements are robust and effective, which creates additional capacity pressures. There is a lack of commissioned health capacity to facilitate optimum effectiveness of MASH information sharing. We saw case evidence in a number of services where key information for which the MASH is the conduit was not sent routinely to frontline services, resulting in safeguarding risk assessment work at the frontline not being fully informed. This was particularly well evidenced in midwifery services and as a result, may prevent midwives across Staffordshire from early, proactive responses to risks of domestic violence and increases the risk that unborn may not be effectively safeguarded.
- 5.1.6 There are further challenges in that front line services are not routinely receiving notifications from the ED or MIU or MASH of incidents of domestic abuse involving pregnant women. A significant contributing factor in this is the lack of commissioned capacity in the health presence in the MASH. The SSOTP safeguarding team supporting MASH activity, routinely send domestic violence notifications to the trust's health visitors. However, there is not an effective pathway in place to all providers to consistently ensure this key information gets out to all relevant services and we saw case examples in midwifery services evidencing that risk assessment is not always best informed to ensure unborns are safeguarded effectively.

- 5.1.7 The MASH leadership group which is the strategic group and includes health commissioners meets six monthly. A strategic management board consisting of the providers involved in the MASH operationally meets on a six weekly basis. At the time of the review the leadership group was considering a review of the MASH operations and business case put forward by the MASH co-ordinator setting out resource model options for the future including options for the commissioning of health support. **(Recommendation 9.2)**
- 5.1.8 Looked-after children are not well served in Staffordshire in relation to the identification and meeting of their health needs over the period of time they are accommodated by the local authority. It is difficult to identify what the partner commissioners and provider agencies are aiming to achieve for looked-after children and the role of the Health and Wellbeing Board in arrangements is also not clear. The current service delivery model commissioned by the CCGs is not fit for purpose. There are over-lapping and duplicate services, none of which are properly linked together to ensure objectives for looked-after children's health are shared and well understood by the professionals working with the child or that outcomes are positive. The support role and performance oversight of the looked-after child health service from the designated doctors and designated nurses was not apparent and the CCGs and children's social care did not have a clear or accurate picture of how health services to looked-after children were being delivered, the quality of what was being provided or resultant outcomes.
- 5.1.9 Reporting mechanisms into the CCGs and the LSCB for performance monitoring in relation to the timeliness of IHAs and RHAs are clear, although senior managers expressed a lack of confidence in the accuracy of the performance data that is being reported. We were told that there was an established performance group with representation from the local authority and CCG commissioning manager to look at performance on IHAs and RHAs in the North of the county and that the designated nurse was a member of that group. It was expected to be a short term group and it was not clear how this group was taking performance forward. No performance group operated for the south. The council, CCGs and designated nurses did not have a strong grip on all aspects of service delivery, quality and timeliness across the county as a whole. There is no appropriately constituted group wherein the partner agencies; Staffordshire County Council, the CCGs, the commissioned health providers – SSOTP and SSSFT for Sustain Plus represented by the appropriate officers come together to focus on quality, operational effectiveness and continuous improvement. It is essential that all agencies take ownership and work together to effect real change through a robust and equitably driven “whole system” approach. **(Recommendation 1.8 and 3.9)**

- 5.1.10 The LSCB coordinated the organisation of the Female Genital Mutilation conference in September 2014 which was attended by 388 delegates from a range of organisations throughout Staffordshire and Stoke-on-Trent. This conference brought agencies together to debate, engage and raise awareness so that strong and effective partnerships can be formed to tackle this serious issue.
- 5.1.11 The LSCB's multi-agency practice guidance for the assessment, management and referral for bruising in a non-mobile baby has been in place across Staffordshire and Stoke-on-Trent since 2014 and was revised in July 2015. The guidance is based on NICE guidance and research evidence, giving clear and succinctly written information to both clinical and non-clinical practitioners. This supports consistent and effective safeguarding practice across health and social care in responding to bruising in very young infants well.
- 5.1.12 The transition by Public Health of the school nurse service to the new provider, Birmingham Community NHS Trust, in September 2015 has been challenging at times but managers have clear aims to develop the service and bring it into line with their other existing areas of school nurse provision in Sandwell and Birmingham.
- 5.1.13 South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) reviewed their safeguarding arrangements at the end of 2014. The review identified several improvements implemented throughout 2015/16; these improvements include reporting systems, governance arrangements and communication with frontline staff. We found there was scope to further strengthen managerial oversight of safeguarding practice in the adult mental health service to ensure good practice is embedded and well evidenced through case records.
- 5.1.14 Leadership through the named GP role is being developed countywide. The three named GPs operating across the South of the county meet regularly. They are beginning to meet with the named GP for North Staffordshire and with the designated leads to promote consistency and work on a common agenda. For example; the named GPs have recently revised and rewritten the training packages and have worked co-operatively to ensure commonality of content and focus. There has been slowing of momentum due to changes in the designated post holders but beginning to regroup and move forward again and establish a new leadership team. None of the named GPs are on the CSE Forum and this is a gap; the risks of CSE, the tools available to assess such risks and the local arrangements for managing CSE risks in individual children were not clearly understood in one of the GP practices we visited. Named GP engagement with the CSE Forum would provide a conduit to facilitate awareness raising of CSE issues and risk assessment among GPs countywide.

- 5.1.15 There is a GP forum in North Staffs meeting three times per year with GPs expected to attend at least one. We were told that some GPs routinely attend all three and this is positive. The forum presents an opportunity for GPs to share cases, and promotes consistent practice through question and answer sessions; topics which have been explored at the forum include Prevent and CSE. There is no GP safeguarding leads forum in the South. We were told that recruitment issues in primary care have made this difficult but GP safeguarding forums are becoming a routine and, in some areas, well established feature and so this is an area for further development.
- 5.1.16 In UHNM, the named midwife provides good leadership and promotes effective safeguarding practices within the maternity service at County Hospital and has been influential in raising the awareness and understanding of FGM and CSE within the Trust. Operational oversight at the midwifery frontline is not yet developed to ensure full practitioner compliance with best practice and trust policies in identifying vulnerabilities as set out above (para 1.9). However, there is good oversight of cases where vulnerability has been identified. The named midwife is appropriately involved in relevant LSCB sub boards and actively raises awareness of the LSCB priorities within the maternity department. The named midwife, head of midwifery and link/specialist midwives are readily available to provide ad hoc staff for advice and guidance to staff as needed.
- 5.1.17 We visited two BHFT provided MIUs; Tamworth and Litchfield on the day where new operating hours came into place following a commissioning review and public consultation. MIU services will no longer be open throughout the night and people needing treatment outside of the reduced opening hours are being directed to other available health services. The challenges of signposting people to alternative services and potential impact on patients seeking treatment were noted but it was too soon to evaluate these.
- 5.1.18 Practice and actions being taking in the MIUs in relation to the transition to a new IT system differed in the two units visited with only one scanning documents onto the new system to give continuity of information to support safeguarding practice. This meant that practitioners in the other unit have no access to information about individuals' previous attendances at the unit prior to March 2016 on the electronic record. Both units recognised the value of this information as they undertake assessments of children and young people yet both have managed the transition to the new system very differently. Access to information on previous attendances by children and young people can enhance the rigor of the current assessment and there would be a benefit in the trust re-considering the adoption of a single robust approach across the MIUs.

- 5.1.19 In common with its other services, South Staffordshire and Shropshire Healthcare Foundation Trust has an identified safeguarding champion for the GUM service it provides in Cannock Chase and County Hospital. However this practitioner was on leave on the day of our visit and practitioners we met were unclear about their involvement in the wider safeguarding and child protection agenda. They did say that in the event of something that gave cause for concern they had good access to advice and guidance from the trust's safeguarding team. We found an over reliance in the service on one key member of staff with a depth of safeguarding knowledge; the safeguarding champion. There was risk in the service therefore, that information was not routinely or fully assessed and addressed in order to minimise potential areas of risk of harm to children.
- 5.1.20 The South Staffordshire and Shropshire Healthcare Foundation Trust GUM service is in the process of introducing electronic records and moving from paper records to electronic recording. At this point in this transition, there is a basic but workable system in place for cross referencing information on previous attendances at the service's other venue to ensure continuity of care between the two services and facilitate effective safeguarding risk assessment. However, we understood from practitioners that the system does not always work well and often succumbs to IT breakdown. At the time of our visit the trust-wide IT system had failed and therefore, new GUM patient records were having to be created by hand. There was no opportunity to check if they had been seen at the other GUM service, thus there was potential for safeguarding risk assessment for new patients not to be fully informed by information held in the service as a whole.
- 5.1.21 In both GP practices we visited there was a clearly identified lead GP for safeguarding children. In one of the practices this role was well-developed with the lead GP taking a proactive role in monitoring and auditing safeguarding activity. This role was much less well developed in the other practice and we identified a number of areas needing to be strengthened in this practice, which the safeguarding lead GP accepted.
- 5.1.22 Since NSCHT was issued with a warning notice by CQC, a lot more attention has been given to CAMHS within the trust and work has taken place with commissioners to provide better information of shortfalls in demand. The service is now benefiting from significant additional investment with 20 WTE new staff in the process of being appointed for North Staffordshire and Stoke on Trent. Service improvement work is resulting in 'root and branch review and reform' with action being taken to deliver services more efficiently and address historical silo working.



- 5.1.23 The NSCHT CAMHs service benefits from strong local leadership and is strengthening its capacity to provide a timely response to high risk/urgent referrals. Additionally, the safeguarding nurse ensures that all frontline staff are aware of any child protection reviews relevant to their casework facilitating their participation. Since the recent appointment of three locum psychiatrists, referrals can now be allocated in accordance with levels of presenting clinical need; including young people with deliberate self-harm. Waiting times for mental health assessments are now minimal being just a few days, and this represents very positive progress given that young people experienced delays of about 12 months previously.
- 5.1.24 NSCHT CAMHs has established a youth council to support a stronger young person culture in the way it undertakes business. The contribution of young people is evident in a number of areas; in the design of the waiting area in the new CAMHs base, changing the time of the management meeting to enable the young person representative who attends college to attend and involving young people in the recruitment and interviews of staff.

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## 5.2 Governance

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- 5.2.1 Overall, governance of looked-after child health by the CCGs across Staffordshire is weak. CCGs have been unaware of the extent of fragmentation and the implications and impact of this in relation to the effective provision of health services to the looked-after child cohort and individual children.
- 5.2.2 There is not sufficient capacity in the combined role of designated nurse for safeguarding and children looked-after which has been established in the North Staffordshire CCG and the South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG, Stafford Surrounds CCG and Cannock Chase CCG partnership in the South of the county. Inevitably and rightly, the two designated nurse post holders' attention is primarily focused on the safeguarding agenda. Arrangements to ensure effective leadership, governance of and support to the commissioned looked-after child health service has not been put in place as a result. We commonly see CCGs investing in a separation of the designated roles to ensure effective and concentrated focus on the safeguarding and looked-after children areas which nationally have both grown in complexity over the past few years.
- 5.2.3 Given both this national and the significant local challenges faced by children's social care and health partnership in such a complex local health commissioner and provider landscape and with over 1000 looked-after children, the current arrangement is extremely hard for the CCGs to justify. An example of the kind of issue which would fall within the discharge of responsibilities of a designated LAC nurse is the issue of ensuring a clear and acute understanding of signing consent for health assessment and consent for invasive treatment. This was raised by foster carers and we also saw a case example of discrepancies in practice within a service. In one case example, this caused a delay in one young person having their operation. (**Recommendation 9.3**)
- 5.2.4 South East Staffs & Seisdon Peninsula CCG operates an Integrated Governance Framework across the three CCGs which work in partnership. A new governance team is in place and work is being commenced to review many of the current governance systems and processes.
- 5.2.5 There are regular operational and steering group safeguarding meetings within UHNM. An annual midwifery service report is produced for the trust board by the named midwife in conjunction with the named nurse for safeguarding children. However, there is no more frequent reporting of safeguarding priorities/workload activity/risks etc within maternity services to the trust senior management and board and reconsideration of this may be opportune as currently there is a reliance on incident reporting to highlight risk issues to the senior management. (**Recommendation 5.4**)

- 5.2.6 In the BHFT midwifery service, there was not evidence of strong managerial leadership in regards to safeguarding practice and governance arrangements were underdeveloped. The existing audit processes undertaken in midwifery are not inclusive of safeguarding. There is no data collected to support effective managerial oversight and performance is not monitored regarding the effectiveness of midwives' safeguarding practice. We saw disparity in case records between management expectations of safeguarding practice and what we saw evidenced in the records. **(Recommendation 4.1)**
- 5.2.7 There is no one complete record for individual women to which BHFT midwives have access. Midwives are expected to record information in different systems. For example a missed appointment may need to be recorded in the community midwifery diary, GP record, antenatal clinic summary card, electronic record and patient health records and the handheld record. It was a challenge for practitioners and managers to locate where copies of referrals made to children's services were stored across the record keeping systems. Navigating multiple record keeping systems is time consuming and an added challenge to midwifery staff. There is a risk that information may not be consistently recorded across the relevant systems. **(Recommendation 4.15)**
- 5.2.8 The BHFT MIUs have a paediatric liaison service provided by SSOTP which visits units or accesses the electronic system Monday to Friday. This is a real strength and provides a good opportunity for a review of the attendances of children and young people to the MIUs to ensure that no safeguarding issues may have been overlooked. The paediatric liaison does not examine every record but is supplied with the data of all children and young people attendances and selects cases for further review and further action if required. This service is valued by staff in both units and appears to work well. Paediatric liaison capacity at the ED at County Hospital is limited and ED alert systems for the management of child safeguarding activity are not fully established, leading to insufficient awareness of children where there are known safeguarding concerns or who are looked after. Capacity to quality assure safeguarding children's work and to move beyond brief information sharing about risks to children presenting within the department is limited.
- 5.2.9 A number of the health providers were in various states of transition between paper and electronic recording systems resulting in hybrid systems where the risk of information going missing or not being immediately accessible to practitioners was high. We found this created barriers to the timely and effective communication and information-sharing within and between the range of local health services and their partners. Full transition to electronic recording should be expedited across the trusts and other provider organisations. **(Recommendations 1.9, 2.2 and 4.16)**

- 5.2.10 Capacity in safeguarding teams across health providers was a concern. With underdeveloped operational oversight of safeguarding practice and other areas for development we identified in safeguarding supervision arrangements, this is an area for commissioners and providers to re-evaluate. (**Recommendation 1.10, 2.3, 3.10, 4.17 and 5.5**)
- 5.2.11 The MIU's moved to an electronic record keeping system in March 2016. Staff are still learning to navigate the system and one consequence of this was operational managers' limitations in being able to interrogate the system fully to support their operational oversight of practice through the electronic record. For example; when we requested to see records of under 18's attending for emergency hormonal contraception this information could not be provided.
- 5.2.12 The robustness of arrangements for monitoring the care of vulnerable children and families differed in the two GP practices we visited. In one practice this was well developed; safeguarding was a standing agenda item at every practice and clinical meeting where the evolving needs of individual vulnerable children were monitored. Whereas another practice we visited had only recently begun to hold quarterly meetings with health visitors where such children were discussed. The lead GP and the practice manager were not clear if they had identified all vulnerable children on their patient list because the practice was reportedly not routinely sent child protection information by the local authority and there was also no fall-back system established that enabled the practice to identify vulnerable children.
- 5.2.13 We saw evidence of NSCHT CAMHs learning lessons from a recent multi-agency learning review through improved awareness of safeguarding risks and the need to put in place support for others within the household in relation to young people who display self-harming and challenging behaviour.
- 5.2.14 The trust was also in the process of conducting an audit of the quality of referrals made to children's social care as part of the trust's audit plan.
- 5.2.15 In NSCHT adult mental health service operational managers in the community mental health teams did not have a clear and complete picture of the profile of child protection or CIN cases within their team caseload, although they were aware of some individual cases. This undermines managers' ability to monitor and oversee safeguarding practice and case load management effectively as well as impacting on workforce training and development planning. (**Recommendation 2.4**)

- 5.2.16 NSCHT adult mental health practitioners are taking ownership for making checks and referrals to children's social care when they identify that the adult with mental health needs has contact with children. They will telephone to see if they are known to children's social care and follow up concerns in writing using the MARF. However, managers recognised that governance of this activity could be strengthened through the trust's safeguarding professionally being routinely copied into such referrals. The trust has not been able to reliably report on referral rates previously but this is now being addressed. (**Recommendation 2.5**)
- 5.2.17 Managers within the adult substance misuse service have a clear and current understanding of all children present within the service's caseload. All cases are monitored in the weekly team meeting with verbal progress update from the case worker. Only nurse co-ordinators have child protection cases on their caseload and cases moved into child protection are re-allocated within the service to these practitioners.

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## 5.3 Training and supervision

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- 5.3.1 Midwives are specifically identified within the inter-collegiate document 2014 as requiring multi-disciplinary, inter-agency level three safeguarding training at specialist level (a minimum of 12-16 hours over a three year period). We were advised that midwives at UHNM County Hospital fulfil the learning hours required and training is provided as single agency in-house and multi-agency via the LSCB and that compliance is monitored. Competencies are reportedly in line with the intercollegiate document.
- 5.3.2 Burton Hospital NHS Foundation Trust midwifery service provides six hours core level three child safeguarding training every three years. There is a reliance on additional topic training eg FGM to meet the requirements outlined for midwives in the intercollegiate document as set out above. The specialist midwife has not undertaken level four training which, given her enhanced safeguarding role in the team, would be more commensurate with her role and responsibilities. (**Recommendation 4.18 and 5.6**)
- 5.3.3 All staff at UHNM County Hospital have been given the opportunity to attend training and awareness raising sessions hosted by the trust on child sexual exploitation (CSE) using well regarded training programmes such as Chelsea's Choice.
- 5.3.4 The two year UHNM preceptorship package for newly qualified midwives has no safeguarding or child protection competencies included within it, rather practitioners are expected to complete safeguarding training within that two year period. For BHFT, safeguarding is built into the two year preceptorship of newly qualified midwives although the trust acknowledged that exposure to all elements of safeguarding work is limited when staff are not in the community. We were told that steps were being taken to enable staff to attend pre-discharge meetings to strengthen their safeguarding knowledge and understanding. Incorporating safeguarding competencies within preceptorship programmes can benefit the learning and practice development of newly qualified midwives, prioritising this essential element of their role at an early stage of their professional career. (**Recommendation 4.19 and 5.7**)

- 5.3.5 In the SSSFT Trust GUM service, we were informed that staff undertake safeguarding training commensurate with their roles and responsibilities in safeguarding young people which should be at level three. However, case evidence seen indicated levels of practitioner awareness of risk assessing for safeguarding issues and particularly CSE is not sufficient strong. Staff reported that they had recently undertaken training in FGM and CSE. They believe that they are unlikely to ever see a case of FGM because of the demographic of the local area being white/UK. It is not clear whether this is taking into consideration transient populations and the changing demographic of the UK. We were told that practitioners receive supervision from the trust's safeguarding team although we were unable to ascertain the frequency and how this was informing practice improvement.
- 5.3.6 NSCHT adult substance misuse practitioner undertake level 3 safeguarding training appropriate for their roles and responsibilities in safeguarding children. However, ADS expectation is set at level 2. From cases sampled in the service, level 2 training is unlikely to be sufficiently in equipping ADS practitioners to discharge their safeguarding responsibilities and it was clear from cases described that practitioners' level of competency is likely to be more commensurate with level 3 training adult substance misuse service has appropriate supervision arrangements in place. This was acknowledged by service managers in ADS. *This has been drawn to the attention of Public Health, Staffordshire County Council as the commissioner of the adult substance misuse service.*
- 5.3.7 University Hospitals of North Midlands NHS Trust has a safeguarding supervision policy in place which offers practitioners across the trust 1:1 or group supervision if required. Some additional provision is made by the named midwife for the cohort of midwives; the named midwife offers group supervision to all midwives and 1:1 debriefing supervision sessions after high risk cases as needed. Advice and guidance is also available to staff via the named midwife and specialist /link midwives as needed. However, overall, trust supervision arrangements for midwives are not fully developed to best support midwife practitioners to discharge their safeguarding roles and responsibilities which are increasingly complex locally, reflecting national trends.

- 5.3.8 As women with complex social issues do not deliver at County Hospital, regular group supervision for hospital staff may well be appropriate to the needs of this staff group. However, the practice of community midwives and specialist link midwives as caseload holders would benefit from regular in depth one-to-one supervision sessions. This would provide opportunity to ensure a degree of professional challenge in cases where increased support or intervention with vulnerable women is identified, reduce the likelihood of potential risk being overlooked and best support practitioners working with potentially highly vulnerable women and unborns. The named midwife receives safeguarding supervision from the North Staffordshire CCG designated nurse for safeguarding but this is not sufficiently frequent to best support professional practice and development with only two sessions taking place in 2015. Both designated nurse and named midwife need to ensure 1:1 supervision sessions take place regularly.
- 5.3.9 Safeguarding supervision is similarly not embedded in frontline practice in BHFT midwifery. We have assurance from BHFT that a formal policy requires staff to attend an agreed number of formal safeguarding supervision sessions. To help address this acknowledged area for development; four midwives have been trained to be safeguarding supervisors. There has been variable uptake by frontline staff, however. We spoke to a safeguarding supervisor for midwifery who has tried to utilise quiet times of clinical activity to facilitate impromptu safeguarding supervision sessions. Whilst this appears to generate reflective discussion in the group which aids learning, the cases discussed did not appear to be active ongoing cases that perhaps would benefit from further analysis of progress. The safeguarding supervisor produces a written record of the session, giving a copy to the midwife and retaining a copy for her records. We would expect to see noted on individual case records that a case had been discussed in safeguarding supervision and any resultant actions. We were not able to review the quality of supervision records held by the supervisor as they were not stored on site which is also not in line with best practice. (**Recommendations 4.20, 5.8 and 9.4**)
- 5.3.10 Staffordshire and Stoke on Trent Partnership NHS Trust FNP and health visitors access appropriate safeguarding children training which is internal and external and fulfils the requirements in terms of competencies and hours of learning as stipulated in the Intercollegiate Document 2014. Practitioners access safeguarding supervision three monthly and have access to ad hoc advice and guidance as needed. Safeguarding supervision is well embedded into their working culture and is robust. The child is central to the process and the paperwork used clearly reflects this. The FNP service has secured the service of a social work manager who attends and supports supervision sessions, which has added a valuable dimension to their discussions. An example of the positive impact of this is demonstrated by a case, referred by a FNP to children's social care and closed following a brief assessment which was re-opened after it was discussed at supervision. Safeguarding supervision discussions and actions are noted routinely within client records in line with best practice.



- 5.3.11 School nurses are required to access 1:1 safeguarding supervision every three months. Birmingham Community NHS Trust has been proactive in employing two named nurses, based locally, to support the delivery of this in the school nurse and special school nurse team.
- 5.3.12 It was difficult to extract the numbers and hours of level 3 child safeguarding training BHFT MIU staff had received due to difficulties in accessing the electronic record system during this review and this warrants further exploration by service managers. It was not clear if the electronic staff record is sensitive enough to check that compliance relates to the number of hours of training as well as the level of training.
- 5.3.13 There is a lead safeguarding nurse in each MIU who attends trust safeguarding meetings and disseminates information to the team. These nurses are paediatric trained and provide day-to-day support and ad hoc supervision to staff but no records are made of actions agreed as a result of these discussions or resultant outcomes. The lead safeguarding nurses have regular contact and formal supervision with the named nurse which is positive and appropriate in supporting them in their role. Both MIUs have found it difficult to arrange more formal supervision on a regular basis for the rest of the MIU practitioners however, due to clinical commitments. This is a gap in ensuring practitioners are fully and robustly supported in their roles; having the opportunity to reflect and challenge their practice to best support professional development. (**Recommendation 4.20**)
- 5.3.14 In NSCHT CAMHS, the trust's named nurse reported that she provides regular group supervision and individual support as and when required for complex cases. This supports supervision already provided by line managers and is in line with trust policy. There is recognition that this could be strengthened to ensure staff are best supported to discharge their safeguarding responsibilities. Similar arrangements for group supervision and ad hoc one to one were in place in SSSFT CAMHS. Best practice would be for practitioners, particularly those who hold cases where there are known safeguarding risks or vulnerabilities, to receive regular, planned one to one safeguarding supervision to facilitate practitioners in reflecting on and challenging their practice. The lack of provision of robust safeguarding supervision arrangements which best support practitioners in the discharge of their responsibilities have featured in serious case reviews and is an area for further strengthening in both trusts (**Recommendations 2.6 and 3.11**).
- 5.3.15 Compliance with expected levels of safeguarding children training within North Staffordshire Combined Healthcare NHS Trust CAMHS remains overall an area for improvement, particularly at level 3 which is what all frontline practitioners need to undertake. Actions to address this deficit form part of the trust's improvement and recovery plan.

- 5.3.16 Staff working in the SSSFT adult mental health service in South Staffordshire have all received training to the appropriate level in accordance with Intercollegiate guidance. Level three training for those staff that interact with or assess clients who are parents or who have access to children takes the form of face to face classroom sessions and this is a recommended model. All staff who are trained in this way also undertake level one and level two training annually through an online programme. However, as set out earlier in this report the impact of the level three training undertaken was not sufficiently evident in frontline practice as demonstrated through the cases reviewed. (**Recommendation 3.12**)
- 5.3.17 The NSCHT safeguarding named nurse currently provides updates to adult mental health staff regarding safeguarding children practice issues. This includes updates on local and national SCRs, the most recent local SCR was based within adult mental health services. Training is also provided face to face and via e-learning. Supervision is offered to staff in line with trust policy. The safeguarding children's nurse acknowledged that this could be strengthened. However, capacity is currently limited due to commitments to the safeguarding agenda. In order to properly ensure that adult mental health practitioners are prioritising the safeguarding of children whilst working with the adult in line with best Think Family practice, it is essential that practitioners are supported through robust supervision arrangements enabling them to reflect and be challenged on their practice to drive continuous improvement (**Recommendation 2.7**).
- 5.3.18 The South Staffordshire SSSFT adult mental health teams, including staff at the perinatal mental health unit, are well supported through a multi-layered safeguarding supervision process. This includes supervision by the team or unit managers, *ad-hoc* advice and guidance in person by the SSSFT safeguarding team as and when it is required and monthly scheduled group supervision facilitated by the named nurse for the trust. We saw that an account of the supervision discussions and the decisions made during the discussions were made on the patients' electronic records. This is good practice as it supports confident decision making and gives clear direction to practitioners.

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## Recommendations

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1. **North Staffordshire CCG, South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG, Stafford & Surrounds CCG, Cannock Chase CCG and Staffordshire & Stoke-on-Trent NHS Partnership Trust should:**
  - 1.1 Work with Staffordshire County Council to put measures in place which ensure that looked-after children have initial and review health assessments within expected timescales and within an effective joint performance management framework that drives continuous improvement across the whole system to achieve good outcomes for young people.
  - 1.2 Ensure an effective quality assurance process is put in place in order that initial and review health assessments of looked-after children are of an acceptable and consistent standard.
  - 1.3 Put measures in place whereby a rolling programme of training is provided to properly equip health visitors and school nurses to undertake high quality review health assessments and develop SMART health plans to meet the health needs of looked-after children.
  - 1.4 Work with primary care services to ensure that GPs are routinely invited to contribute information about the health of looked-after children to initial, where appropriate, and review health assessments.
  - 1.5 Ensure that strengths and difficulties questionnaires (SDQs) are used to inform looked-after children review health assessments with the participation of the young person where possible.
  - 1.6 Work with partners to ensure the pathway for police notifications of domestic abuse incidents involving pregnant women to go to midwifery services works efficiently and effectively across Staffordshire.
  - 1.7 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.
  - 1.8 Work with Staffordshire County Council to identify a clear and shared strategy in relation to the provision of effective health support to looked-after children and young people. Review the current service delivery model in light of these shared objectives; putting into place effective governance and operational oversight arrangements in a “whole system” approach that delivers good outcomes.

- 1.9 Expedite the transition to electronic recording to ensure that complete and comprehensive patient records are accessible to frontline practitioners and managers.
- 1.10 Ensure the trust's safeguarding team has sufficient capacity to fully discharge their responsibilities in leadership and governance of safeguarding practice.

**2. North Staffordshire CCG and North Staffordshire Combined Healthcare NHS Trust should:**

- 2.1 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.
- 2.2 Expedite the transition to electronic recording to ensure that complete and comprehensive patient records are accessible to frontline practitioners and managers.
- 2.3 Ensure the trust's safeguarding team has sufficient capacity to fully discharge their responsibilities in leadership and governance of safeguarding practice.
- 2.4 Ensure the unit managers of the adult mental health service are aware of all current children on CIN and child protection plans and that this is clearly evident in the electronic case management system.
- 2.5 Ensure appropriate arrangements are in place to quality assure safeguarding referrals made to children's social care and to provide managers within the trust with appropriate safeguarding activity data commensurate with effective governance.
- 2.6 Ensure that CAMHS practitioners' safeguarding practice is well supported by regular, planned and recorded supervision to facilitate continuous professional development.
- 2.7 Ensure that robust supervision arrangements are put in place to support adult mental health practitioners effectively in discharging their child safeguarding responsibilities.

**3. South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG, Stafford & Surrounds CCG, Cannock Chase CCG and South Staffordshire & Shropshire NHS Foundation Trust should:**

- 3.1 Ensure that strengths and difficulties questionnaires (SDQs) are used to inform looked-after children review health assessments with the participation of the young person where possible.

- 3.2 Ensure that documentation used in the GUM service is age appropriate; encourages practitioners' exploration and evaluation of the presenting factors in order to robustly assess risk, mitigate harm and develop intelligence for the wider multi-agency arrangements and is subject to effective operational governance.
- 3.3 Work collaboratively to ensure that information on parental mental health and/or substance misuse including relapse indicators and contingency plans are routinely shared with community health practitioners, with appropriate consent, to promote effective team around the family multi-disciplinary practice.
- 3.4 Develop the understanding of all managers and practitioners in the adult mental health service to recognise the significance of the impact of parental mental ill-health on children and to articulate that as part of formal risk assessments and care plans.
- 3.5 Ensure that for every case where clients are identified as having access to children staff complete a standardised child safeguarding risk assessment and act on the outcome.
- 3.6 Ensure, through effective quality assurance, that frontline operational managers support practitioners in making safeguarding referrals that articulate risks to the child clearly in order to support optimum decision making in the MASH.
- 3.7 Ensure that appropriate flags are promptly applied to the client's electronic case record to alert CAMHS practitioners to children known to be at risk and that the system is kept updated.
- 3.8 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.
- 3.9 Work with Staffordshire County Council to identify a clear and shared strategy in relation to the provision of effective health support to looked-after children and young people. Review the current service delivery model in light of these shared objectives; putting into place effective governance and operational oversight arrangements in a "whole system" approach that delivers good outcomes.
- 3.10 Ensure the trust's safeguarding team has sufficient capacity to fully discharge their responsibilities in leadership and governance of safeguarding practice.
- 3.11 Ensure that CAMHS practitioners' safeguarding practice is well supported by regular, planned and recorded supervision to facilitate continuous professional development.

- 3.12 Ensure that processes including robust supervision, are in place to evaluate the impact of child safeguarding training on the practice of adult service practitioners.
- 3.13 Ensure an effective quality assurance process is put in place in order that initial health assessments of looked-after children are of an acceptable and consistent standard.

**4. East Staffordshire CCG and Burton Hospital NHS Foundation Trust should:**

- 4.1 Ensure effective managerial oversight and governance arrangements are in place in the midwifery service to provide assurance to the trust board that safeguarding practice is robust.
- 4.2 Ensure that midwifery antenatal documentation and operational practice oversight are effective in order that midwives consistently identify and record when pregnant women are at risk of domestic abuse in line with trust policy and best practice.
- 4.3 Ensure that processes are in place whereby midwives are notified of expectant women's attendance at ED and MIU.
- 4.4 Ensure the guidance to staff governing the admission of pregnant women via the ED includes the consideration of potential safeguarding risks.
- 4.5 Ensure that electronic recording systems are fit for purpose and that patient records are complete, current and comprehensive of all events and safeguarding information relating to individual patients.
- 4.6 Put processes in place to ensure that MIUs take steps to confirm parents have taken their child to another location for further assessment or treatment as required.
- 4.7 Ensure that the full names of adults accompanying children and young people to the emergency department are recorded in the patient record to support effective risk assessment.
- 4.8 Ensure that documentation in use in the adult and paediatric ED has prompts and triggers which supports consistent best safeguarding practice including the identification of the potential for hidden harm to a child.
- 4.9 Ensure that practitioners in the MIUs are well supported in identifying children at risk of hidden harm and child sexual exploitation through the provision of appropriate risk assessment documentation and effective operational governance arrangements.

- 4.10 Ensure that practitioners in the MIUs are well supported through appropriate mental health training and assessment tools to undertake mental health assessments of young people, subject to effective managerial governance arrangements.
- 4.11 Ensure, through effective quality assurance, that frontline operational managers support practitioners in making safeguarding referrals that articulate risks to the child clearly in order to support optimum decision making in the MASH.
- 4.12 Work with Staffordshire County Council to ensure that prolonged in-patient stays for medically fit mothers and babies are avoided whenever possible.
- 4.13 Ensure practitioners are knowledgeable and compliant with the policy on how to respond when adults and /or children present for treatment for dog bites.
- 4.14 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.
- 4.15 Ensure record management systems are in place that facilitate practitioners' and managers' access to current and comprehensive case records relating to individual patients.
- 4.16 Expedite the transition to electronic recording to ensure that complete and comprehensive patient records are accessible to frontline practitioners and managers.
- 4.17 Ensure the trust's safeguarding team has sufficient capacity to fully discharge their responsibilities in leadership and governance of safeguarding practice.
- 4.18 Review safeguarding training to ensure alignment with intercollegiate guidance and that it is properly equipping all practitioners to discharge their safeguarding roles and responsibilities.
- 4.19 Ensure the midwifery preceptorship programme fully encompasses safeguarding and child protection competencies as well as the requirement for training in order that best safeguarding practice is embedded at the outset of midwives careers.
- 4.20 Ensure that safeguarding supervision arrangements are appropriate and robust to best support practitioners in discharging their clinical and safeguarding responsibilities.

**5. Stafford & Surrounds CCG and University Hospitals of North Midlands NHS Trust should:**

- 5.1 Ensure that midwifery antenatal documentation and operational practice oversight are effective in order that midwives consistently identify and record when pregnant women are at risk of domestic abuse in line with trust policy and best practice.
- 5.2 Ensure, through effective quality assurance, that frontline operational managers support practitioners in making safeguarding referrals that articulate risks to the child clearly in order to support optimum decision making in the MASH.
- 5.3 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.
- 5.4 Review reporting arrangements in maternity services to the trust's board to ensure the board is informed with sufficient regularity of operational risks and issues.
- 5.5 Ensure the trust's safeguarding team has sufficient capacity to fully discharge their responsibilities in leadership and governance of safeguarding practice.
- 5.6 Review safeguarding training to ensure alignment with intercollegiate guidance and that it is properly equipping practitioners to discharge their safeguarding roles and responsibilities.
- 5.7 Ensure the midwifery preceptorship programme fully encompasses safeguarding and child protection competencies as well as the requirement for training in order that best safeguarding practice is embedded at the outset of midwives careers.
- 5.8 Ensure that safeguarding supervision arrangements are appropriate and robust to best support practitioners in discharging their clinical and safeguarding responsibilities.

**6. Birmingham Community NHS Trust should:**

- 6.1 Ensure an effective quality assurance process is put in place in order that review health assessments of looked-after children are of an acceptable and consistent standard.
- 6.2 Put measures in place whereby a rolling programme of training is provided to properly equip school nurses to undertake high quality review health assessments and develop SMART health plans to meet the health needs of looked-after children.



- 6.3 Work with primary care services to ensure that GPs are routinely invited to contribute information about the health of looked-after children to review health assessments.
- 6.4 Ensure that strengths and difficulties questionnaires (SDQs) are used to inform looked-after children review health assessments with the participation of the young person where possible.
- 6.5 Ensure consistent follow-up responses to children's attendances at emergency departments and MIUs.
- 6.6 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.

**7. Staffordshire and Stoke NHS Partnership Trust should:**

- 7.1 Ensure transfer in arrangements across health visitor teams are robust in order that women experience seamless health visitor support.
- 7.2 Work collaboratively to ensure that information on parental mental health and/or substance misuse, including relapse indicators and contingency plans, is routinely shared with community health practitioners, with appropriate service user consent, to promote effective team around the family multi-disciplinary practice.
- 7.3 Ensure that information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.

**8. NHS England and Staffordshire CCGs should:**

- 8.1 Work with primary care services to support best practice and enable GPs to routinely contribute information about the health of looked-after children to initial, where appropriate, and review health assessments.
- 8.2 Work with GP practices across Staffordshire to support the development of multi-disciplinary vulnerable families meetings.
- 8.3 Work with GP practices across Staffordshire to develop effective risk assessment tools, knowledge and process to identify young people at risk of child sexual abuse and exploitation and ensure appropriate action is taken.
- 8.4 Work with GP practices to improve engagement with and participation in child protection processes.

- 8.5 Work with GP practices to help them ensure that the information coming out of MARAC on protective actions needed to safeguard individual unborns, children and young people at risk due to domestic violence is well secured on the case record to inform frontline work with the family effectively.

**9. North Staffordshire CCG, South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG, Stafford & Surrounds CCG and Cannock Chase CCG should:**

- 9.1 Work with local hospital trusts and Staffordshire County Council to ensure that protocols for consent for invasive clinical interventions are clear, consistent and well understood in order that looked-after children have prompt access to said interventions.
- 9.2 Ensure that there is sustainable health presence in the MASH with capacity to support the effective information gathering and sharing to facilitate optimum decision making to safeguard children, young people and families.
- 9.3 Review the roles, responsibilities and capacity of the designated nurses for safeguarding and looked-after children and ensure that these are appropriate to discharge the full range of required activity to lead and support and oversee continuous improvement in safeguarding practice and the provision of effective health support for looked-after children.
- 9.4 Ensure that robust supervision arrangements for named professionals are in place to best support professional practice and development.

**10. North Staffordshire Combined Healthcare NHS Trust should:**

- 10.1 Work collaboratively to ensure that information on parental mental health and/or substance misuse including relapse indicators and contingency plans are routinely shared with community health practitioners, with appropriate consent, to promote effective team around the family multi-disciplinary practice.

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## Next steps

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An action plan addressing the recommendations above is required from North Staffordshire CCG, South East Staffordshire & Seisdon Peninsula, East Staffordshire CCG, Stafford Surrounds CCG and Cannock Chase CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk). The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.