

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

Children Looked After and Safeguarding

The role of health services in Warwickshire

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| CCGs included: | Warwickshire North CCG South Warwickshire CCG |
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Summary of the review

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

About the review

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

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

How we carried out the review

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

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

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

In total, we took into account the experiences of 102 children and young people.

Context of the review

Children and young people under the age of 20 years make up 22.6% of the population of Warwickshire with 15.5% of school age children being from an ethnic minority group. On the whole, the health and wellbeing of children in Warwickshire is generally similar compared with the England average. There are variations in the level of need across the two CCG's with north of the county showing higher levels of need. Hospital admissions caused by injuries in children (0-14 years) are 121.0 per 10,000 which is above the national figures of 109.6 per 10,000. Hospital admissions as a result of self-harm are also above the national average by 7%.

The DfE reported that Warwickshire had 460 looked after children that had been continuously looked after for at least 12 months as at 31 March 2015. Local data for the overall number of children placed by Warwickshire has seen a rise of 10.7% from March 2015 (690 Looked after Children) to March 2016 (764 Looked after Children). Warwickshire County council also notes the number of children recorded as asylum seekers has risen by 89% between March 2015 and March 2016.

A strengths and difficulties questionnaire (SDQ) is used to assess the emotional and behavioural health of looked after children within Warwickshire. The most recent SDQ score (2015) was 13 compared to the England value of 13.9. The average score has decreased since 2013, this suggests that the emotional health and wellbeing of looked after children in Warwickshire may be slightly improving.

Commissioning and planning of most health services for children are carried out by Warwickshire North Clinical Commissioning Group (WNCCG) and South Warwickshire Clinical Commissioning Group (SWCCG) . Most local residents are registered with GP that is a member of one of the CCG's. There are 75 practices across the two areas. The commissioning landscape includes Coventry and Rugby Clinical Commissioning Group (CRCCG) covering part of Warwickshire, this is recognised within the safeguarding arrangements across the county. The CRCCG were inspected in 2015 and therefore did not form part of this inspection.

The designated nurse for safeguarding is employed by North Warwickshire CCG and has a service level agreement to undertake the role on behalf of South Warwickshire CCG to support a collaborative approach across the two CCG's, a similar arrangement is in place for the designated doctor. There is an additional cross cover arrangement as required by the designated nurse with Coventry and Rugby CCG.

Acute hospital services are commissioned by both CCG's and are provided by South Warwickshire Foundation Trust (SWFT) at the Warwick Hospital and George Eliot Hospital NHS Trust. Our review included visits to the trust's emergency department (ED), children's assessment unit and maternity services. Acute and Maternity services are also commissioned by Warwickshire and Coventry CCG's at University Hospital Coventry and Warwickshire.

Health visitor services are commissioned by Warwickshire County Council Public Health and provided by SWFT.

School nurse services are commissioned by Warwickshire County Council Public Health and provided by Compass.

Commissioning arrangements for looked-after children's health are the responsibility of South Warwickshire Clinical Commissioning Group. The looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by South Warwickshire Foundation Trust (SWFT)

Specialist child and adolescent mental health services (CAMHS) are provided by Coventry & Warwickshire Partnership Trust (CWPT), the lead commissioner for this service is Coventry and Rugby CCG). In-patient care tier 4 CAMHS is commissioned nationally by NHS England.

Maternal and mental health services are provided by Coventry and Warwickshire Partnership Trust.

Contraception and sexual health services (CASH) are commissioned by Warwickshire County Council Public Health and provided by George Eliot Hospital NHS Trust and GPs.

Adult mental health services are provided by Coventry & Warwickshire Partnership Trust (CWPT).

Adult substance misuse services are commissioned by Warwickshire County Council Public Health and provided by Addaction on behalf of Coventry and Warwickshire Recovery Partnership.

Child substance misuse services are commissioned by Warwickshire County Council Public Health and provided by Compass.

*The last inspection of health services for Warwickshire children took place in October 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The overall effectiveness of the safeguarding services including for looked after children was judged as **good** with the contribution of health agencies to keeping children and young people safe as **adequate**. Progress against inspection recommendations have been considered in this review.*

The report

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

What people told us

A mother told us;

"I booked via my midwife at the GP surgery and everything was sorted straight away. I've been given everything I need and I don't want to go anywhere else to have my baby"

Another mother who had just given birth to her second child told us;

"I had my other child at another hospital and it was a horrible experience. This has been so different, I had perinatal care and it's excellent. The community midwife was good too and I've already met my health visitor"

A set of parents with a baby due told us;

"My only issue is that it's impossible to get thorough on the hospital switchboard but once here the care is fine"

A foster carer told us;

"We have an amazing health visitor. She visits us every week because the baby has such complex health needs. She goes above and beyond to support us."

Young people in care told us;

"The nurse gives me plenty of time to sit down and talk. If I want information, she is able to give it to me or goes away and gets it and lets me know".

"I had a health review in a health centre. It was alright and they were kind to me. I didn't have a choice about where it was though, they just told me it would be at the health centre".

"I had to go to the hospital for an ear infection. I don't like needles and we were both telling them that but they weren't listening. I have autism. They should have listened to me and the foster carer about how I would best be treated. All doctors and nurse should be trained on how to deal with autism".

"My GP is great. I've known him since I was five. He understands autism".

"I have just got an appointment for what will be my last health assessment. As a care leaver, I should be getting a health passport. I expect it to have useful information I can keep and that I can give to my GP".

The child's journey

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

1. Early help

- 1.1 The consultant and midwifery care lead at George Eliot Hospital NHS Trust (GEHT) offers a flexible approach to expectant women accessing maternity services either through their GP Practice, via other professionals or self-referral to a community midwives. Midwifery care is patient-centred with bookings and antenatal appointments undertaken in a variety of settings including the woman's home.
- 1.2 The GEHT maternity services have established a specialist midwifery team to provide care to those women with high level of social vulnerability. We saw evidence of specialist midwives undertaking home visits, liaising with relevant services, sharing information and working jointly with social workers to ensure that vulnerable women and teenagers are well supported. Community midwives can refer to the two midwives who then offer care to this cohort of women, we saw in records how this assisted in the coordination of complex cases.
- 1.3 Warwick Hospital community midwives maintain their safeguarding expertise by supporting women with increased vulnerability including child protection. This approach ensures continuity of care from initial booking for women needing multi-agency support to safeguard the unborn during pregnancy.
- 1.4 Both maternity units identify and support young mothers during pregnancy and offer the option of early referral to family nurse partnership (FNP). This is a positive step in tailoring care to this group to assist them in maintaining a healthy pregnancy and building knowledge for their future parenting role.

- 1.5 Expectant women with mental health concerns are well supported by a NICE guidance (CG192) compliant perinatal mental health pathway in both hospital units. Perinatal mental health training has been delivered by the perinatal mental health service manager to community midwives, which has supported them in identifying emerging mental health issues. Although there are no specialist midwives for perinatal mental health at present, women with an identified high level of need are supported to access appropriate services by the community midwives. We saw evidence in one case of the birth and discharge plans of a mother with mental health issues being explicit in management to reduce the risk of exacerbating her condition.
- 1.6 Practitioners spoke positively of the perinatal mental health service and we saw collaborative working with other professionals in most cases we reviewed. The perinatal mental health service report good working relationships with the hospitals' specialist and community midwives, health visitors and FNP practitioners countywide. However, we noted perinatal mental health and health visitors placed an over-reliance on the more formalised liaison taking place at safeguarding meetings, rather than evaluating women's care jointly on a more regular basis.
- 1.7 Health visitors follow NICE guidance (CG192) to assess emotional health during the antenatal period and this is a positive step. However, we heard there is no formal pathway or partnership agreement from midwifery to health visiting which would support effective liaison and joint working. Therefore, opportunities for sharing information and jointly coordinating early help may be missed. We saw one record where a CAF could have been commenced earlier in pregnancy, it was reported verbal discussions had taken place between midwife and health visitor at handover, however there was not written evidence of this in the paper records.
- 1.8 The health visiting early help offer is strong. The CAF process is fully embedded and we saw evidence of some good early intervention work to support vulnerable families with health visitors confidently taking the role of lead professional. Health visitors have also established good links into local nurseries and developed a leaflet to promote the health visiting services to parents. Alongside this, the FNP programme is well established, and cases we reviewed highlighted positive outcomes for young people and their infants supported by the service.

Case Example 1: At a new birth visit, the health visitor found the home environment to be overcrowded and the mother presenting with mental health concerns. The health visitor referred the family to the children's centre requesting a family support worker and also opened a CAF. Disclosures of the father drinking alcohol and being aggressive towards the mother led to a referral and discussion with the MASH, the decision was to continue with the CAF with the health visitor as lead professional.

The health visitor visited the family every 2-3 weeks over a 7 month period to offer support and ensure the children's safety. The health visitor showed a good level of professional curiosity to support her continued risk assessment and a high level of multiagency liaison with the GP, school head teacher, family support worker, housing officer and school nurse to ensure coordinated support for the family.

Case Example 2: A Family Nurse Practitioner (FNP) was effective in supporting a young mother whose child was subject to a child protection plan. There had been some resistance to engaging with the service but with time the young mother had built a strong therapeutic relationship with the nurse practitioner.

The young person was in need of mental health services but due to service criteria was finding it difficult to access the right service as she was approaching the cut-off age for children's services. The work was necessary to support the young person come to terms with childhood experiences and be able to develop a positive parenting approach with her own baby. The FNP played a key role in coordinating referrals and appointments and acted as an advocate when service criteria barriers presented.

- 1.9 Health visitors reported that telephone calls or paper notifications were received when safeguarding concerns were raised by the emergency departments. However we did not see any evidence of routine notification of attendance at unscheduled settings and therefore were unable to assess the role they may take in initiating early support or referral to appropriate services. Health visitors have a primary prevention role in following up ED attendance and advising on safety in the home and building confidence in parents to manage of minor illnesses. This can also support the child accessing the appropriate medical intervention which at times may not be the emergency and unscheduled settings. Multiple attendances may also be an indication of underlying safeguarding issues within the family.

- 1.10 The school nursing service is delivering an innovative computerised health assessment programme known as 'Health Awareness Prevention and Intervention' to reception and year six children. This is part of the early help offer to families. The computer programme assists parents and children to complete health assessments through an IT portal which parents can complete at home or in school. The programme allows the school nursing team to target children for one to one support dependant on any identified issues raised, ranging from bullying to healthy eating. The assessment is in addition to the universal offer of the National Child Measurement Programme at reception and year six. The year six health assessments are completed by children in school, this helps children to consider their own health needs. Uptake of the assessment for the first 10 months it has been operating has been 70%, exceeding the commissioner's target for the service at this stage.
- 1.11 GP's are notified of all ED attendances, however GPs told us that the level of detail within the notifications on the nature and circumstances surrounding the need for treatment from the ED departments at GEHT and Warwick hospitals is variable. Some notifications from GEHT reviewed were found to be illegible, leaving the GP unable to assess the clinical or social impact of the attendance. This may impact on the GP's ability to be fully appraised of a young patient's health and wellbeing at future consultations and plan any follow-up treatment. A recommendation in the 2011 Safeguarding and Looked after Children inspection related to improving information and quality of notifications from ED and unscheduled settings. This work has not been fully embedded into practice.
(Recommendation 4.1 and 5.1).
- 1.12 There is not a consistent process in SWFT Minor Injury Unit (MIU) for alerting community nursing practitioners of children's' attendances in the unscheduled settings. Records of children attending MIU are reviewed weekly by a hospital link health visitor before dissemination to health visitors and school nurses. This is an unnecessary delay in initiating early help or if more serious concerns are missed in the first instance.
(Recommendation 5.2).
- 1.13 Warwick ED has a robust process in place for sharing information with universal services. A paediatric liaison nurse provides daily independent oversight of each child's attendance at ED to identify any missed opportunities to escalate any safeguarding concerns. Where children or families would benefit from additional support, the details are called through to the relevant health visiting or school nursing team. Processes are also in place to support the identification of the 'hidden child' within families where adult behaviours can impact on the child. When alerted by adult ED, the liaison nurse reviews the ED cards of adults who have attended with concerning behaviours where they have access to children.

- 1.14 As part of an early help offer, a positive initiative has been put in place by the Recovery Partnership at Warwick emergency department. The role of the Hospital liaison worker is to support and work with substance misusers and this includes review of all the ED cards of adults who attend with features of alcohol or drug misuse, or who present with mental ill-health and this supports identifying the hidden child. The practitioner is available during working hours to offer direct support to any patient in ED. The Hospital Liaison worker primarily works with adults over the age of 18 years, however the service liaises with Compass for Children and young person's referrals to the CYP's substance misuse service. This supports young people with substance misuse problems being offered access to the appropriate advice via ED or soon afterwards through consensual referral to Compass young people substance misuse programme. However, this provision is not available in GEHT and therefore there is inequitable access to early help for this cohort of young people in the North of the county. Given the higher than national average hospital admissions due to substance misuse in 15-24 year age group across Warwickshire, this is a gap in service. *This has been brought to the attention of Warwickshire County Council Public Health.*
- 1.15 Compass provides a service to young people who are misusing substances and has identified a cohort of children who would benefit from additional support due to the impact of their carers' substance misuse. They are developing a strand of the service known as 'Hidden Harm', and a comprehensive assessment tool is being used. Self or professional referrals are taken for 5-24 year olds. We saw case examples where this was making a difference to children's lives. This is a positive initiative and evidences responsiveness by the service to the local emotional wellbeing of a vulnerable group.

Case Example: *Compass young people's substance misuse service was working with a young person in a special guardianship placement who was displaying difficult behaviours but not reaching the threshold for support from other services. The young person met the criteria for the new Compass service working with children of parents that have misused drugs.*

An intensive piece of work was undertaken with the child and family, including the child developing her own care plan which addressed areas of, 'who is important to me' and 'who makes me feel safe'. Prior to the work the carer reported the family had been at breaking point but following the intervention by Compass and support given to the young person felt the placement was sustainable

- 1.16 Young people have good access to a range of sexual health clinics across the county. As part of the local offer, the GEHT integrated sexual health service runs a number of 'chat clinics' in conjunction with other services in young people friendly environments. The service builds on a 'one stop' offer to young people, bringing together targeted youth workers, a charity to support young people with housing as well as a sexual health and contraception service. This is good joint working across services to meet the needs of young people.
- 1.17 GEHT is working effectively with a number of sixth form colleges undertaking 'pop up' sessions promoting sexual health services on a six monthly basis. Drop in clinics are also available in some schools with sixth forms. Practitioners were keen to develop this part of the service to assist young people to access services in locations that are convenient to them. Both approaches support young people in being informed on maintaining their own sexual health and developing positive relationships.
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2. Children in need

- 2.1 The waiting area of the children's assessment unit (CAU) at GEHT is not in permanent view of the nurses' station and so staff are unable to make observations to detect any children whose condition may be deteriorating. There is also makes observations of the interactions between children and the accompanying adult more difficult. Although the environment is focused to the needs of children, audited observational processes of the areas would improve the safety of the child. The potential risks were brought to the manager's attention. (**Recommendation 4.2**).
- 2.2 In the Children's Assessment Unit (CAU) at GEH we saw examples of good, detailed record keeping by the paediatric nurses in the narrative section of the notes, and some good examples of the identification of and response to safeguarding concerns.

Case Example: *In one case reviewed at George Eliot Hospital CAU, unexplained bruises had been discovered on examination of a child who had originally presented with a different complaint. The level of identified risk to the child was evolving due to changes in the engagement and cooperation by child's parent with their child's assessment.*

The records noted these changes and the child's responses to the parent's behaviour. The nursing notes demonstrated good professional curiosity by the nurse, a very quick referral to the local authority, on-going dialogue with the duty social worker and management of the evolving risk whilst the child and the parent were still at the hospital.

This led to timely and appropriate intervention by children's social care and the police, the child subsequently became subject of a child protection enquiry in relation to suspected physical abuse.

- 2.3 During a CQC regulatory inspection of ED at Warwick Hospital May 2016, it was identified that the children's waiting area was out of view of the nurse's station. The trust has implemented a policy of ensuring that the waiting area is checked every 20 minutes by the nurse in charge for the purpose of identifying a poorly child. However these regular visits are not monitored. We acknowledge there has been an improvement in the process however this remains an area for further development. (**Recommendation 5.3**).
- 2.4 The paperwork completed on attendance at GEHT ED unit does not support practitioners to identify safeguarding risks and prompt professional curiosity through the use of appropriate triggers and prompts. In ED and CAU the assessment tool is generic therefore when adults are seen, practitioners may not consider and gather information of the impact of adult behaviours known to be a risk to children. Therefore the opportunity to use the information to inform risk to children is lost. (**Recommendation 4.3**).
- 2.5 In the GEH ED and CAU, we saw that there was no scope within the generic emergency department documentation record (ED-record) to record key information, for example the child's family or school, social worker and what the relationship is between the child and the person who accompanied them. In most records seen in the paediatric ED's, important information such as the parental responsibility was not completed. These are missed opportunities to consider how the child's social context will inform the care, line of enquiry and advice offered. (**Recommendation 4.4**).
- 2.6 Warwick hospital and the Minor Injuries Unit (MIU) at Stratford the adult ED-record is limited in ability to support the practitioner to identify the 'hidden child'. The absence of sections about the patient's family means that the identification of children to whom the patient has access to is reliant on the curiosity of staff. Although we did see examples of good practice in the case of an adult who attended having taken an overdose where young children were identified, this approach was not consistently demonstrated and not supported by the limited format of the ED-record. (**Recommendation 5.4**).

- 2.7 The paediatric ED-record at Warwick has the provision for recording child focused demographics, however an audit carried out by SWFT at the hospital in June 2016, the data indicated that there was a shortfall in staff completing the demographic details on the paediatric ED-record and this accorded with our findings. The records also include prompts related to identifying non accidental physical injury through an algorithm. The algorithm was seen to be completed in all but one case record. The records go some way to supporting the practitioner in assessment but the focus on physical injury limits its potential for identification of broader safeguarding issues.
- 2.8 Neither GEHT nor SWFT ED units assessment documentation have a section to capture the 'child's voice' or indicate if the child had been asked to provide their own history or to prompt the practitioner to assess the child's competence to consent in their own right. CQC's national report *'Not seen Not Heard'* (2016) identifies the risks associated with a deficit in capturing the child's voice in health settings. Key information to support safeguarding decisions would be strengthened by the routine consideration and recording in both units ED of the child's perspective where age appropriate (**Recommendation 4.5 and 5.5**).
- 2.9 Child and Adolescent Mental Health Services (CAMHS) have extensive waiting lists which are impacting on the service delivering early support and intervention in a timely way. Current waiting times for follow up appointments are well in excess of 18 weeks. Referrals to CAMHS T1, 2 and T3 services are via a single point of access (SPA) team, with triaging by specialist practitioners. Following initial assessment, processes are in place to review and manage referrals allowing a 'stepping up or down' of a case, therefore giving clinical and managerial oversight of those children waiting to be seen. Access to CAMHS and waiting times for therapeutic intervention are a well-known challenge to commissioners and providers, however extended waits for therapeutic input is likely to result in detriment to children and young people's emotional wellbeing and has already been highlighted in the recent CQC inspection. (**Recommendation 7.1**).
- 2.10 Emergency department staff at GEHT and Warwick Hospital spoke positively of the CAMHS offer delivered by the acute liaison team (ALT). The team is available Monday-Friday, 9-8pm with 24hr on call access to a paediatric psychiatrist. The ALT undertake comprehensive mental health assessments of children and young people who present at ED services and we saw good evidence this is happening. All attendees are provided with a seven day follow-up post discharge. If the young person is already known to CAMHS, the case worker visits and if not previously known the ALT worker will undertake the follow-up. This is good practice in ensuring that services are responsive to children's needs after leaving the hospital.

- 2.11 There are good systems in place to ensure the safety of patients admitted with self-harming behaviour at Warwick Hospital. Young people who self-harm are transferred to the paediatric ward until they are medically fit to be assessed by the ALT. Once transferred a risk assessment is undertaken that relates to potential for self-harm and considers the safety of others. The risk of suicide is considered using a numerical scale and enables ward staff to plan with ALT for the patient's discharge.
- 2.12 We saw evidence of appropriate interpretation of the local authority threshold document for children and young people attending with self-harm behaviours in both hospitals. Attendees at the ED department trigger a referral to the Single Point of Entry (SPE) for a CAMHS assessment and young people in both ED units are automatically subject to a referral to the MASH to ensure their needs are properly considered.

Case Example: *In the case of one young person with mental health issues the risk assessment had been used to good effect to support her whilst she remained on the ward for medical treatment arising from an intentional and significant overdose.*

The quality of the nursing and clinical notes were exceptional and enabled any staff member taking responsibility for her care, shift by shift, to have a full understanding of her current situation and levels of anxiety, with reference to the patient's management plan.

We looked at the MASH referral for this young person and saw that it too had been completed in detail providing the MASH with a clear picture of the unusual circumstances that had led to her overdose, thus supporting optimum decision making.

- 2.13 Young people over the age 16yrs attending ED's with mental health issues can choose to be seen in adult ED's, where they are seen by the adult mental health team in accordance with commissioning arrangements. A Coventry and Warwickshire Partnership Trust (CWPT) pathway then ensures there is a child focused oversight, with all cases referred to CAMHS ALT for follow up. This gives choice to the young person while still enabling appropriate services to support the young people on discharge.
- 2.14 We heard of good practice when young people with mental ill health require in-patient treatment in Tier 4 provision. CAMHS practitioners are diligent in supporting the young person from a distance and maintain contact through visits, texts and telephone and participate in reviews of the young person's progress. This on-going contact supports vulnerable young people to build trusting relationships with the adults working with them and can facilitate earlier discharge from in-patient units that are at long distances from the child's home community.

- 2.15 In CWPT adult mental health documentation, including the initial assessment tool, does not support the identification of children who are dependants or have frequent contact with the adult receiving adult mental health care. We did see in one case a practitioner had recorded the children's details in the free text box and this was good practice in ensuring the children's details were captured, although these details would not be "pulled" through into the case record by a free text record. In adult mental health there is a need to continually evaluate the vulnerability of children whose parents are being supported with mental health condition. Due to limitations in the electronic recording system, there is a risk of children becoming less "visible" in the case record over time and this does not help adult service practitioners be sighted on the child in their day to day practice. (**Recommendation 7.2**).
- 2.16 There is not a consistent approach across the locality for health visitors to meet with GP practices. All GPs have a named health visitor and there is an expectation by SWFT managers that monthly vulnerable families meetings are held, although compliance is not currently monitored. We heard from primary care settings that meetings are not established as routine across the county. Where we see these established in other areas, they can be very effective in identifying need early and ensuring that vulnerable children and families received early help support promptly (**Recommendation 1.1**).
- 2.17 Compass school nursing service recognises it does not currently have a close working relationship with CAMHS and joint working needs to be strengthened. A meeting is planned with CAMHS as part of the transformation programme. Compass has also identified a skills gap in school nurses confidence in supporting young people's emotional health and are looking to facilitate specialist training. This will be a positive step in supporting a growing cohort of children and families needing low level emotional health care.
- 2.18 There is a lack of assurance that children and parents/carers known to Warwickshire County Council Local Authority who are out of school or being home educated are aware of the new school nursing service and the universal offer. The safeguarding issues with this cohort of children has been raised nationally and cited in serious case reviews (SCR), as the children can become hidden from partner agencies often by parental non engagement. Compass has identified this deficit and is working with the local authority to facilitate the sharing of information.

Case Example: *A woman aged 25 with diagnosed schizophrenia with a child aged three years was attending the GP regularly due to her mental health issues.*

It was noticed by reception staff and the GP that the woman paid little attention to the child and was always on her mobile phone. The child appeared to take little interest in things around him, had underdeveloped language skills and showed signs of neglect.

The GP raised the case with the health visitor and it was identified that the father took the main responsibility for child care and the child was receiving little interaction or stimulation within the home.

A GP referral was made to children's social care. As a result, the case was allocated to a social worker and the family were engaged with the children's centre. A family support worker also worked with the family.

The parents have now engaged well with services and continue to be supported. The child's development has significantly moved forward and language skills are much improved as a result of needs being identified early and an effective early help package of support being put in place promptly

- 2.19 The Recovery Partnership (RP) substance misuse service does not routinely undertake home visits on clients living with children and storing medication at home. This is a missed opportunity to take a more detailed review of the home environment and deliver onsite education of safe storage to minimise risks to child. We were advised practitioners would not routinely liaise with the health visitor who could reinforce safe storage advice. *This has been brought to the attention of Warwickshire County Council Public Health.*
- 2.20 Compass young people's substance misuse service and Recovery Partnership both have transitional case workers who jointly assess which service would be the most suitable to support the young person. This is undertaken on case by case basis and with full knowledge of the young person. This demonstrates patient focused care alongside well developed multidisciplinary working.

3. Child protection

- 3.1 GEHT have a clear expectation that midwives screen for domestic violence at least twice antenatally during a woman's episode of care. This was not evidenced in records seen, and management advised a process was now being established to support this happening and to monitor this activity. Research recognises the increased risk of domestic abuse in pregnancy and processes should ensure steps are taken to identify and support this group of women. (**Recommendation 4.6**).
- 3.2 Warwick Hospital midwives ask a routine enquiry question on domestic abuse as a standard three times in both the antenatal and postnatal period. This was evidenced in records seen and is good practice.
- 3.3 GEHT has established processes to ensure the care plans for unborns are available and easily identified on women's records. At Warwick Hospital there are robust processes to ensure signed birth plans and discharge plans are sought from children's social care and available within the electronic records. However those seen had been received from children's social care without signatures of either the parent or social care, therefore health staff are not clear on parental knowledge of the steps being taken to protect the unborn.
- 3.4 There is a strong focus on domestic abuse within the health visiting team. All health visitors have attended domestic abuse training and some practitioners have completed the Freedom training programme. Health visitors regularly make referrals to the Multi Agency Risk Assessment Conferences and will attend to present cases. In several records reviewed routine enquiry was being used and health visitors were noted to be supporting parents in understanding the impact of domestic abuse on their children, this gave assurance domestic abuse was an area of focused work to safeguard children.
- 3.5 In GEHT ED, referrals to the Multi Agency Safeguarding Hub (MASH) are made using the multi-agency referral form (MARF) although its use and the standard of content are variable. We saw some good practice examples, where practitioners and clinicians had identified risk and taken appropriate action, taking care to record accurate and complete information on the referral form.

Case Example: *At George Eliot Hospital, a child had attended the ED with a high temperature, accompanied by their sibling, and their mother, who had driven the children to the hospital whilst very drunk.*

The mother shared that the family were known to children's social care and the details of the social worker were recorded on the record. Part of the examining clinician's documented plan showed that the matter was to be referred to children's social care and the patient records showed that the social care emergency duty team (EDT) were contacted within 16 minutes of the child's attendance.

The plan included that the practitioner would complete a MARF in an appropriate referral to the MASH. This demonstrated nursing and medical diligence and accurate identification of the risk to these children. The record also showed significant dialogue between the paediatric nurse and the EDT and the police about managing the safety of the child during the discharge process. Not only was this evidence of good record keeping, but it also ensured that the children would not be placed at further risk when discharged.

- 3.6 We were not assured that care plans developed by adult mental health practitioners working with adults with mental health issues are routinely linked to any current child protection plan for the children in their clients' care. Therefore, the day to day work of the adult mental health practitioners with the client may not take the needs and risks of the children into account. This may impact on the ability of the practitioner to ensure the child's safety remains paramount when case managing the adults. **(Recommendation 7.2).**
- 3.7 We saw case examples of a lack of direct liaison between midwives, health visitors, GP's, adult mental health, school nurses and CAMHS outside of formal child protection and Child in Need (CiN) meetings across services. Information sharing is crucial to effectively safeguarding children and young people. Poor communication is a common feature of serious case reviews including a recent Warwickshire case. This is an area for development across these services. **(Recommendation 4.7, 5.6, 6.5 and 7.3).**

- 3.8 We found good commitment by all provider services to ensure practitioner attendance at case conferences and core groups is prioritised. However not all organisations monitor attendance or routinely quality assure reports. There is also a variation in the submission of reports to child protection conferences. For example SWFT midwives provider a report if they are not able to attend, where they do attend a report is not submitted, whilst Recovery Partnership attend or submit reports. In CWPT, compliance with reporting and attendance at child protection conference is not consistent. In school nursing provided by Compass, reports are not being provided for review conferences. This is not in accordance with the Warwickshire Safeguarding Children Board child protection procedures (4.11), which states, 'All involved professionals should; *produce reports for the Child Protection Review*'. A written report offers evidence of each practitioners assessment of risk and strengths within the family, providing the conference with an holistic view of the child and their family circumstances. This assists at conference in evaluating the child's welfare and enables the conference to make fully informed decisions about the help and support that can be provided to meet the child/young person's needs. (**Recommendation 5.7, 6.1, 7.4 and 8.1**).
- 3.9 The ability of practices to plan ahead in order to participate in child protection conferences needs strengthening. In common with other areas, most GPs in Warwickshire are not aware that the date of the next child protection child protection conference is included in the minutes of the previous one. Warwickshire County Council has recently informed all agencies, through child protection conference minutes, that it has ceased sending out separate invitations to conferences and the date should be taken from the minutes. The Designated Nurse took prompt action during the inspection to make GP's aware of the change in practice.
- 3.10 GP Participation in case conferences across the county varies .Two of the three GP practices visited submit child protection conference reports, and make committed efforts to regular attend child protection conferences and this is commendable. The third practice did not submit reports routinely or send a response to the conference unless they feel they have a concern. The practice acknowledged this area for development and is taking action to strengthen their practice. No template has been developed to guide GP's in completing reports and there is no guidance on what information would be useful to child protection conferences. (**Recommendation 2.1**).

Case Example: *A GP had made a referral to CAMHS in which he asked for assessment of a young person who appeared to be developing agoraphobia. The CAMHS team responded and assessed within two weeks.*

The young person was found to have multiple complex needs including self-harm, unresolved grief and potential sexual exploitation, none of which had been identified in the GP referral.

The worker flagged the concerns with the CAMHS manager and the safeguarding team which resulted in referral to MASH for a more detailed assessment

- 3.11 Within provider organisations, the use of electronic flagging systems for safeguarding alerts on children and adults records were not always robust. In GEHT and SWFT midwifery services' IT systems the alerts were accessible and appropriate. However, the health visiting paper record system does not facilitate practitioners in flagging the records with safeguarding concerns. School nursing electronic records do not flag children at risk of harm and there is no standardised operating procedure for recording safeguarding concerns within the records. The CWPT mental health IT system does not have the facility to flag cases where there are known to be vulnerable children, including those on child in need or child protection plans. This creates risk that practitioners and managers accessing client records may not be immediately alerted to the presence of a child (the in adult records) and, particularly, a child known to have increased vulnerability who may not then be safeguarded from risk of, or actual, harm. (**Recommendation 5.8, 6.2 and 7.5**).
- 3.12 In the three GP practices visited we saw good use of flag alerts on patient records. This supports staff in being vigilant and in taking appropriate action to safeguard the health and wellbeing of children and young people. We also saw evidence within the recently established *Safeguarding: GP Self - Assessment Tool* that the use of Read codes forms part of the audit. This will offer a level of assurance to the CCG and NHS England that appropriate coding is being used on vulnerable children's records.

- 3.13 We were advised the WSCB has recently updated the Child Sexual Exploitation protocol, including the screening and risk assessment tools. However staff knowledge of these was not embedded in all services. For example, in sexual health services the British Association for Sexual Health and HIV (BASHH) tool ‘*Spotting the Signs*’ is starting to be used in some clinics to support practitioners and, in Warwick Hospital ED we saw a less comprehensive screening tool in use. Although it was positive that a substantial number of staff spoken to had received the LSCB training, the different models in use suggested that provider staff were not familiar with, or using, the new LSCB protocol. An understanding of risk and referral pathways by frontline practitioners supports a coordinated timely response by partner agencies to children at risk of CSE. **(Recommendation 4.8, 5.9, 6.3 and 7.6).**
- 3.14 Frontline health practitioners are not sufficiently well engaged in the multi-agency sexual exploitation (MASE) meetings arrangements, and this is impacting on agencies ability to coordinate care of vulnerable young people. An example being, GEHT sexual health service are not informed of the cohort of children considered to be at CSE risk who may be using their service and are therefore not in a position to work in partnership with other agencies to safeguard the child accessing the service. We understand that discussions have commenced within the MASE group on the appropriate membership. **(Recommendation 4.9).**
- 3.15 Processes are underdeveloped for identifying female genital mutilation (FGM) within GEHT integrated sexual health service although a number of staff had undertaken specific training. Identifying and supporting women to access appropriate care forms part of the raising awareness and subsequently protecting children and young girls in the future **(Recommendation 4.11).**
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4. Looked after children

- 4.1 Looked after childrens’ (LAC) health needs are not being met in a timely manner when first coming into care and this is an area for improvement. There are delays in the looked after health team receiving paperwork from the local authority, as a consequence timescales for completion of IHA are well below expected levels. A review of data in June 2016 by the local authority found the rate for initial health assessments (IHA) meeting statutory guidance timescales to be 22% when the date was adjusted to the date the child entered the care system and not when the paperwork had been received by health. **(Recommendation 2.2).**

- 4.2 Although the designated nurse meets on a regular basis with social work team managers to review timeliness of health assessments, this has not been effective in driving forward improvements. Once in the health system clinicians are seeing 95-100% of those children for their IHA within 10 days, indicating that the process to arrange a clinic appointment and assess the child's health is working efficiently within the specialist looked-after child health service.
- 4.3 The development of the integrated care pathway (ICP) is positive. It is a comprehensive joint working document between health and social care that provides a clear process for the arrangement, delivery and dissemination of statutory health assessments for Warwickshire looked after children. The ICP is a good foundation on which the partnership can move the LAC service forward and if followed, will support meeting IHA timescales.
- 4.4 When a child or young person becomes looked after, there is a well-established process of children's social care routinely sending the child's care plan and then the placement plan to the LAC health team. This is good practice. By routinely securing this in the child's health record at this stage, there is every opportunity for the information to go with the child on their journey through care and thereafter be known to them when they become care leavers as young adults. However, case evidence showed that this information is not always being used to inform the final RHA and is not being routinely included in the young person's care leaving health passport (**Recommendation 5.10**).
- 4.5 All IHA of children and young people taken into the care of Warwickshire County Council are undertaken by a small team of appropriately qualified consultant and specialist paediatricians in line with intercollegiate guidance and best practice. At the conclusion of the IHA, the paediatrician indicates the most appropriate practitioner to undertake subsequent looked-after child health assessments. Those children with the highest levels of health needs or vulnerability receive care from the paediatrician or the specialist looked-after nurses. The process recognises the complexity of needs of some LAC and specialist care needed by this group.
- 4.6 There is a robust pathway in place for the completion of adoption medicals. The looked after children's team are completing 100% of these health assessments on time. There is a dedicated medical advisor (paediatrician) and the reports for adoption panel reviewed were of a good standard.
- 4.7 It is a strength that all looked after children in Warwickshire over the age of 4 years and up to 18 years have a strengths and difficulties questionnaire (SDQ) completed to assess their emotional health and wellbeing. Carers are routinely being asked to complete the SDQ for those under 11yrs. From 11yrs the practitioner completes the SDQ with the young person. This supports the young person to manage their health and wellbeing and track their own emotional growth over time, which is good practice.

Case Example: *A health assessment completed by the school nurse was a detailed, personable and comprehensive appraisal of the young person's health needs.*

The health assessment gave insight into the child's demeanour and relationships with carers, the SDQ was completed with the carer and this was clearly used to assess emotional health and wellbeing.

The health action plan was of a good standard and reflected all aspects of the assessment. A stamp indicated the review had been quality assured by the designated nurse.

- 4.8 Review Health Assessments (RHA) completed by the health visiting team were of a good standard with timely and accountable health action plans. It was clear in all RHAs seen that the health practitioners across the disciplines take time with the young person to gain their trust and make the health review child centred. We gained a good sense of the child as an individual in most cases. They would be further strengthened by greater use of the child's actual words to best reflect the voice of the child. While RHA undertaken by school nurses were comprehensive and child focused, there were some instances of health plans being task rather than objective focused with loose timescales and accountabilities.
(Recommendation 6.4).
- 4.9 The designated and specialist looked after nurses carry out all review health assessments for Warwickshire children aged 16-18years and this is inclusive of unaccompanied asylum seekers. This is providing a consistency of care. This is within capacity, otherwise young people are reviewed by LAC health paediatricians if capacity issues arise. Although positive, it has been driven by commissioning arrangements in regard to the school nursing service not being commissioned to undertake RHAs for this age group. We heard case examples where the designated looked-after children's nurse has developed positive relationships with young people and their foster carers over a period of some years.
- 4.10 Processes are in place through a single point of access and comprehensive database for all health assessment requests to be monitored for Warwickshire children placed out of area and therefore supports their health needs being met. A level of continuity for the looked after child to maintain a relationship with a health professional while placed out of area is provided for those living up to 20 miles who continue to be seen by the SWFT LAC team. Although this is a limited service it does offer continuity to a cohort of children who often have multiple professionals in their lives.

- 4.11 There is a pragmatic approach in the looked-after child health team to supporting the health of young people who move within neighbouring authorities at times which are close to them transitioning into adult services. Positive relationships with designated leads in neighbouring authorities facilitate smooth transitions for these young people and we heard some case examples that illustrated this.

Case Example: *Young male looked-after child from out of area aged 17 years with complex health needs and learning disability moved from Warwickshire special residential school placement into Coventry and therefore should have been transferred into Coventry & Rugby CCG looked-after child health team as now he was officially a Coventry child.*

However, rather than put an additional transition step into the young person's pathway, Warwickshire designated doctor and the designated looked-after child doctor in Coventry agreed that he would continue to be held by Warwickshire health team until such time as he transitioned into adult services in Coventry. This was clearly beneficial to the young person and facilitated an effective single step transition

- 4.12 GPs are not fulfilling their role and responsibilities for looked after children in Warwickshire. The designated nurse designed a GP information sharing pathway and standardised letters advising when the assessment was due and included the format for GP's to share information. Their use was not supported by GP's and currently primary care information held by GPs is not being shared to inform initial and review health assessments. (**Recommendation 1.2**).
- 4.13 Good attention is paid to gaining appropriate consent for the health review to proceed. Young people who are competent are routinely signing their own consent. This is positive, encouraging the young person to take responsibility and have control over the monitoring and management of their health and wellbeing.
- 4.14 The specialist looked-after child nurses are diligent in trying to engage young people who are reluctant to have their health needs reviewed, particularly those who are care leavers. This has significantly reduced the number of *Do Not Attend*s from 40% to 3%.

Case Example: *A recent care leaver aged 19 living on his own in a flat, had declined his last RHA. The Looked-after child nurse worked through and with the social worker to encourage him to be seen and he agreed for the nurse to make a home visit.*

This resulted in him having a detailed discussion with the looked-after child nurse about a range of health and wellbeing issues and any concerns or queries he had in an environment that he was comfortable with. The young person fed-back that he had found the discussion valuable and he was glad that he had engaged with the nurse after all.

- 4.15 The care leavers' pathway has been developed with the involvement of young people and the health support offer to care leavers is developing well. The final RHA is undertaken by one of the specialist looked-after child nurses and case records demonstrated that these reviews are comprehensive including some examples of discussions on a range of issues pertinent to the young person leaving care. These could include on-going access to health support and the young person's plans for their future. There is scope to develop documentation and recording further so that there is a consistent demonstration of these RHAs being the last one for the young person as managers felt that the nature of the discussion held is not always well reflected in the documentation.
- 4.16 The health passport is developed by the health practitioners after the final review and sent to the young person rather than being co-produced in the health assessment. In the final RHA of one unaccompanied asylum seeking child (UASC), there was no mention of the health passport and providing a passport was not included in the young person's final health plan. It is essential that all young care leavers benefit equally from the provision of their individually developed health passport. (**Recommendation 5.11**).
- 4.17 The LAC health team has a good awareness and understanding of the potential health and wellbeing needs and issues likely to be experienced by unaccompanied asylum seeking children (UASC). Practice is informed by the Royal College's guidance on the undertaking of health assessments for UASC. The designated looked-after children's nurse delivers training in the use of interpreters and the health team who undertake the IHAs have had training on the asylum seeking experience which informs their practice in assessing the health needs of this vulnerable cohort. A rolling programme of regular refresher training would be best practice and it was not clear how recent training had been undertaken.

- 4.18 Children needing additional support for their emotional health and wellbeing are benefitting from a timely referral to 'Journeys' which is the early help support for lower level emotional health needs as part of the CAMHS continuum to meet different levels of need. Currently, Journeys and CAMHS do not routinely write to the looked after children's team to inform them of any plans of care they are providing and this is a missed opportunity to ensure the looked after health assessment is holistic and fully informed. (**Recommendation 7.7**).
- 4.19 We saw evidence that the "Journeys" counselling support which is available to young people in care is valued by young people who access it and children who are engaged with Journeys and whose mental health needs escalate are fast-tracked into mainstream CAMHS.
- 4.20 There is no separate dedicated CAMHS LAC service. If LAC children and young people are identified at single point of entry (SPE) as requiring assessment they are expedited and seen within nine weeks from referral to initial assessment instead of the standard target of 18 weeks. However there is a long delay in moving from initial assessment to therapeutic support. We heard CAMHS do try to respond promptly to direct requests from the designated doctor for looked-after children. However it was not clear how the CAMHS restructuring and transformation programme would address this gap in service provision. (**Recommendation 7.8**).
- 4.21 To date, the designated doctor and nurse for looked-after children have not been engaged in the work to deliver the transformation of CAMHS. As a result, there is some concern in the LAC health team that the needs of looked-after children including the increasing cohort of UASC, may not be fully considered in service development. (**Recommendation 5.12**).

Case Example: *In 2013, a care leaver was instrumental in developing a set of playing cards, UR Say, UR Play, to be used by young people who are teenagers and are looked-after. Each card covers a different topic such as Your Rights, Your Say, Safety in the home and in the community, Warwickshire Voice for Youth, West Midlands Job Portal, domestic abuse and many other topics. Each card can be scanned into an i-phone which directly accesses the relevant website with detailed information on the particular topic. The pack exactly emulates a pack of playing cards and is highly visually appealing. All older looked-after children receive a pack of these cards for their own use.*

- Hits on the websites included within the UR Say UR Play playing card packs have increased since the packs of cards were introduced indicating that these are providing signposting to young people that is beneficial and meeting a need.*

- The cards are being reviewed and updated to include information on issues such as sexual exploitation*

This represents a good example of co-production by a care leaver with assistance from SWFT Looked After Children's Team and Warwickshire County Council

Management

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

5.1 Leadership and management

5.1.1 The establishment of the multi-agency safeguarding hub (MASH) in Warwickshire in May 2016 is a positive development. We understand the CCG is moving towards a health presence in the hub but this is a current deficit in joint working. We see the location of health representatives with the appropriate skills to offer health advice and prompt availability of clinical information to inform the decision making process's as an important step to safeguarding children. (**Recommendation 2.3**).

- 5.1.2 The designated nurse works effectively across the three CCGs; North and South Warwickshire CCGs and Coventry and Rugby CCG, in order to support statutory requirements and safeguarding board responsibilities. This collaborative relationship is a positive step between Coventry and Warwickshire safeguarding nurses to deliver a coordinated approach for advice and support to the CCGs in respect of the safeguarding children agenda.
- 5.1.3 The capacity and ability of the designated Nurse for LAC to undertake effective strategic development of looked after children's health in Warwickshire is impeded by the role being in the provider service. A large proportion of her time is taken up by clinical and operational management of the provider LAC team. We were advised the CCG are progressing moving the role from provider organisation to commissioning this will support the development of the strategic role.
- 5.1.4 The CCG's are working towards incorporating the designated LAC role into the current designated nurse for safeguarding role. The capacity to fulfil both roles will be challenging. The Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework (2014) notes in relation to designated posts "local CCGs should consider the range of duties for any post, whilst ensuring that the workload is realistic". We were advised the CCG plan to undertake a six month review of the joint arrangements to ensure both elements of the strategic role are being met. **(Recommendation 2.4).**
- 5.1.5 We found good leadership, support and guidance provided to services and frontline staff by all provider safeguarding teams, designated doctors and the designated nurses for safeguarding.
- 5.1.6 The establishment of the CWPT specialist perinatal mental health service across Warwickshire in November 2015 is an achievement of which commissioners and provider can be proud. The provision of this service ensures that mothers across Warwickshire experiencing perinatal mental health difficulties have equitable and prompt access to specialised support in line with national guidance and best practice.
- 5.1.7 The two GEHT specialist midwives exceed Royal College Midwives national guidance on client to community midwife ratio. However the model of all vulnerable women being referred to the specialist midwives reduces the opportunity for skill development for the community midwives in safeguarding case management. Management highlighted they are aware of this risk. **(Recommendation 4.11).**

- 5.1.8 There is an inherent risk that the level of work undertaken by the named midwife at Warwick Hospital is not sustainable due to lack of capacity. A database supports the oversight by the named midwife and managers of the high risk case work and predominant issues. However at the time of the review, the named midwife provided advice and consultation to community midwives, had oversight of 67 cases of vulnerable women and their babies in addition to the other safeguarding work streams. **(Recommendation 5.13).**
- 5.1.9 CWPT has made an explicit commitment that the adult mental health service will deliver a service model that demonstrates Think Family practice and this is positive. The new safeguarding lead in the trust has set the Think Family agenda as a high priority and the concept is actively promoted through the CWPT safeguarding training. However, systems, processes and frontline operational leadership and governance arrangements are not yet in place which will deliver on this commitment and the trust is some way from being able to demonstrate that Think Family is embedded in frontline practice. **(Recommendation 7.9).**
- 5.1.10 While we saw positive safeguarding practice in the three GP practices visited and identified some good practice case examples; overall, primary care in Warwickshire is behind the national pace within the practice settings. The appointment of a named GP for WNCCG and SWCCG, now holding the role across the whole county is positive as the role will provide leadership, support and a drive for improvement to primary care. The named GP is committed to developing the role and is formulating priority objectives to take safeguarding practice in primary care forward.
- 5.1.11 Compass school nursing transformation plan will include delivering services up to 25years for those children with special educational needs. This is a positive step to working in conjunction with the SEND code of practice of service delivery to young people up to the age of 25yrs.
- 5.1.12 Compass as a newly commissioned service has started to evidence their commitment to coproduction and user involvement shaping services. Four children and young people groups looking at service development have been established across the county.

5.2 Governance

- 5.2.1 The CCG have a robust assurance framework for its main providers. The 'Marker of Good Practice' tool sets out how NHS South Warwickshire Clinical Commissioning Group offers assurance that SWFT and GEH will deliver healthcare to Warwickshire residents and fulfil their statutory duties to children including annual update of Section 11 Audit of Safeguarding Arrangements. The tool forms part of the governance reporting and offered evidence on a number of key safeguarding areas including the scrutiny of progress by the organisations on staff training data.
- 5.2.2 We heard and saw evidence of operational provider safeguarding meetings and governance structures that inform organisations of the safeguarding activity and risks.
- 5.2.3 Practitioners spoke positively of the development and service the multi-agency safeguarding hub (MASH) is delivering. The MASH accepts referrals from practitioners on a multiagency referral form. Although a number of good quality referrals were seen, organisational quality assurance processes, in CWPT, Compass School and Health & Wellbeing service, GEH and SWFT undertaken by frontline operational managers are not in place. The lack of quality assurance activity by operational managers diminishes the opportunity to tailor training to staff needs and improve quality to ensure it becomes embedded. This in turn best supports optimum decision making in the MASH to protect children from harm. Some of the organisations had recognised the shortfall and were considering an audit process.
- 5.2.4 The GEH trust bi-monthly joint agency safeguarding meetings with the local authority operational lead, attended by the safeguarding lead nurse and the named doctor are a positive initiative aimed at driving improvement.
- 5.2.5 There is a lack of managerial or clinical scrutiny of the records of children's attendances at GEHT ED and CAU to determine whether the child should have been subject to a formal referral to universal services at any earlier opportunity. This is compounded by their only being weekly collection of ED-record information by a health visitor. (**Recommendation 4.12**).
- 5.2.6 The current SWFT health visiting paper record is not facilitating practitioners to consider family structures and significant adults in the child/young persons life. The section within the record for parental details is limited and does not support the assessment of risks and protective factors, this is particularly relevant in relation to identifying males forming part of the wider family unit an area highlighted within national Serious Case Reviews. (**Recommendation 5.14**).

- 5.2.7 SWFT have identified a shortfall in the receipt of child protection conference reports from the local authority for children who are of school age. We are advised that this is due to the trust no longer providing the school nursing service and the local authority sending those reports to the current provider of the school nursing service instead. This means that children of school age who are newly made subject of a child protection plan will not appear as an alert on the trust's electronic patient records system, leaving staff within ED unsighted on key information that would affect their approach to clinical consultations. Appropriately, this has been escalated to the trust's risk register and the issue is being dealt with at executive level.
(Recommendation 5.5).
- 5.2.8 The quality of initial and review health assessments varied from poor to a high standard and highlights the need for a more rigorous quality assurance approach. The current process of 'looking at' a comparatively small number of health assessments without a bench marking tool is not effective in continuously ensuring and improving standards for health assessments. Although there are some quality assurance processes in place within the looked-after child health team, this is an area to be strengthened.
(Recommendation 5.16).
- 5.2.9 The health services for looked after children and young people (HELAC) group had not, over time, been effective in driving improvement in overall performance on the timeliness of IHAs. A "task and finish" group had been convened by SWFT with local authority involvement to review overall LAC performance. We were advised that as part of the redesign of the strategic partnership and governance arrangements, including the designated roles and responsibilities for safeguarding and looked-after children, a new strategic governance meeting involving senior managers from all agencies was about to be convened. This will support the development of a whole system approach in which all three partners; Warwickshire County Council, the CCGs and SWFT take equal responsibility.
- 5.2.10 We were advised the LSCB threshold document is not used to support referrals from this service. Although we saw case examples which demonstrated adult mental health practitioners identify risks of harm to children and young people subsequent referrals to social care did not always clearly articulate these risks. The use of a threshold document assists the multi-agency response to the identified risk and enables the appropriate support to be being offered to the child and family.
(Recommendation 7.10).

- 5.2.11 Read coding of child protection cases in primary care is a priority area for improvement to ensure accuracy. In all three primary care practices visited, we saw cases where there are children subject to child protection plans that had been incorrectly coded on the EMISS system as being on the child protection register rather than coded to being on a child protection plan. Both codes are being used interchangeably and this is impacting on the terminology being used verbally by primary care staff and clinicians. This can lead to confusion about the child's legal status and undermines the confidence of other professionals in health staff and practitioners' knowledge and understanding of child protection procedures. This can be quickly resolved countywide and all three practices visited took prompt remedial action to address this in their service. (**Recommendation 2.5**).
- 5.2.12 One of the GP practices visited was not scanning child protection plans into the patient record and this supported the view there is mixed understanding across primary care about how these should be kept. It is essential that child protection child protection conference minutes and child protection plans are on patient records in order that the record is comprehensive and the child protection plans inform day to day practice. The GP acknowledged this deficit and took immediate remedial action to address this for all relevant patients. (**Recommendation 1.3**).
- 5.2.13 The development of the Safeguarding: GP Self -Assessment Tool has the potential to be a significant asset in supporting GPs to safeguard children and young people effectively. It is a straightforward and comprehensive audit tool further strengthened by the embedded link to the RCGP & NSPCC GP self- assessment toolkit. Regular use of this new audit tool would strengthen governance of safeguarding practice within and across primary care practices in Warwickshire. (**Recommendation 1.4**).
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5.3 Training and supervision

- 5.3.1 CAMHS, both services provided by Compass, CWPT and Recovery Partnership practitioners are trained to level 3 safeguarding children and compliance is monitored. This meets with intercollegiate guidance for practitioners working with children and families being equipped with safeguarding knowledge and understanding specific to their roles and responsibilities.
- 5.3.2 The realignment of training requirements by GEH and SWFT organisations against the intercollegiate documentation and roles and responsibilities is a positive move towards ensuring that staff are trained to the required standard commensurate for their professional accountability and the needs of children. Both organisations have processes in place to monitor uptake and compliance is being scrutinised by the CCG through quality assurance processes.

- 5.3.3 Children and young people attending GEHT ED and Warwick Hospital paediatric departments are seen and treated by nursing staff who are appropriately trained and have increased insight into child development and are attuned to their needs. This is in line with RCPCH standards for emergency care settings.
- 5.3.4 There is good safeguarding training provision and compliance in Recovery Partnership, including the commissioning of the NSPCC to provide a bespoke course *Family Environment 4 Drug Using Parents (FEDUP)* for all practitioners. This shows organisational commitment to developing a 'Think Family' approach.

Case Example: *A woman patient was identified as fabricating a pregnancy. A referral was made to mental health services by midwifery services and it was subsequently identified that the woman posed a potential risk of abducting a baby because of her mental health difficulties. The case was appropriately managed through a high level of multiagency working.*

As part of case reflection training and learning, an exercise was arranged. The hospital staged a mock-up of an abduction of a baby from the neonatal ward to identify risks and learn from the exercise.

Following the learning from this case, the organisation has reviewed the security and visitor policies, with changes implemented to improve safety for new-borns. A business case has also been put forward for service improvement including tags for the new-borns.

- 5.3.5 Newly qualified midwives at SWFT are subject to a 12 month preceptorship competency based programme to ensure that they are competent to work to a Band 6 level. However there is no separate safeguarding module as part of that preceptorship programme and this is an area for development. (**Recommendation 5.16**).
- 5.3.6 Newly qualified health visitors benefit from a preceptorship period which includes completion of safeguarding competencies. All new starters have to complete an introduction which includes safeguarding competencies and this is good practice.
- 5.3.7 All three GP practices visited spoke positively of the value of the Identification and Referral to Improve Safety (IRIS) training. IRIS is a general practice-based domestic abuse training support and referral programme and works through collaboration between primary care and third sector organisations specialising in domestic abuse. It has successfully raised awareness of a range of safeguarding issues including domestic violence, sexual exploitation and FGM. We saw and heard cases identified as safeguarding concerns resulting in referral as a direct outcome of this training.

Case Example: *A woman with a three-year old child attended the GP surgery and was observed to be crying by the receptionist as she waited to be seen.*

The receptionist alerted the GP who was able to raise this with the woman in her appointment.

The woman consequently disclosed the domestic abuse she had been experiencing in her relationship with the child's father. As a result of the IRIS training the practice had recently undertaken, the GP was able to explain what help and support was available to the woman and gave her one of the IRIS lip balms which has a helpline number.

As a result of this response by the GP the woman was able to access support from the IRIS advocate and is no longer in the abusive relationship.

The GP was able to reflect this positive outcome back to the receptionist reinforcing her good practice.

- 5.3.8 A robust supervision offer is in place for midwives in GEHT. Monthly 1:1 safeguarding supervision is provided by the named midwife to the specialist midwives who carry cases of highest vulnerability. Alongside this, a separate supervision session 'debrief case' is undertaken by a psychologist from the perinatal mental health service. This is good practice. However, supervision outcomes and actions resulting from the discussion are not being recorded in the patient record. (**Recommendation 4.13**).
- 5.3.9 There is a good safeguarding supervision offer from CWPT encompassing adult and child mental health services. CAMHS offer a consistent supervision framework. New staff are provided with four weekly supervision for the first six months of their employment. All staff with child protection cases have 1:1 safeguarding supervision provided on a 12 weekly basis. Group supervision is also offered to all staff as part of the provision by the safeguarding team. There is a template for use and the expectation is that a copy of the safeguarding supervision forms part of the patient record. The policy was implemented in September 2015 with an audit of effectiveness and compliance being undertaken at the time of this CLAS review. However, it was noted in the cases sampled a record of the discussion and the decisions resulting from supervision are not routinely noted on the client record. (**Recommendation 7.11**).
- 5.3.10 Not all frontline managers in CWPT adult mental health are aware of the trust's policy and expectations in regards to supervision and frontline line adult services are not monitoring compliance. As a result, some adult mental health service practitioners are not benefitting from regular 1:1 safeguarding supervision to support them in safeguarding children effectively. (**Recommendation 7.12**).

- 5.3.11 Recovery Partnership has a strong framework for supervision, staff having monthly 1:1 supervision and case management review. Actions from supervision were not seen to routinely be added to the child's record. **(Recommendation 8.2).**
- 5.3.12 SWFT community midwifery practitioners are offered three monthly 1:1 supervision and we were told the capacity of the safeguarding midwife does not allow for any more frequent sessions. In cases sampled, supervision was not directly referenced and evidenced in the records but records did demonstrate discussion with the safeguarding midwife. **(Recommendation 5.18).**
- 5.3.13 We were told due to SWFT safeguarding team capacity, health visitors attend either group or one to one supervision every 3-4 months. There is a risk that a health visitor may only ever attend group supervision and not take the opportunity to discuss case specific concerns in a 1:1 session, the safeguarding team recognise this is a risk. We are advised that the named nurses are attending the NSPCC supervision course to upskill some of the health visiting team to offer safeguarding supervision. We saw evidence of when the safeguarding team had been contacted for ad hoc advice, this was recorded in client's records with a detailed and timely action plan. **(Recommendation 5.19).**
- 5.3.14 Supervision arrangements in school nursing are not offering the opportunity for 1:1 supervision to enable the practitioner to both reflect and be challenged to support their practice on complex cases including child protection. Practitioners receive group supervision 3-4 monthly, ad hoc safeguarding advice and guidance is available. **(Recommendation 6.6).**
- 5.3.15 There is a good offer of managerial and peer supervision for the designated and named nurse for looked after children. However both nurses continue to have a clinical role and there is no formal offer of safeguarding supervision on a one to one case specific basis and this was identified as a gap in practice. When ad hoc supervision is held on a specific case this is not being recorded in the child's records. This is not best practice. **(Recommendation 5.20).**

Recommendations

- 1. NHS England , Warwickshire North Clinical Commissioning Group and South Warwickshire Clinical Commission Group should ensure that:**
 - 1.1 They work with Compass School Health and Wellbeing Service, CWPT, GEHT and SWFT to gain assurance that interdisciplinary (GP's, midwives, health visitor, school nurses and mental health services) communication is embedded in practice and evidenced through governance arrangement.
 - 1.2 GP's meet their statutory duties in respect of Initial and Review Health Assessment of Looked after Children.
 - 1.3 Child protection conference minutes and plans form part of the GP practice record.
 - 1.4 Support is offered to GP practices to undertake an annual audit of safeguarding practice with outcomes informing the Named GP safeguarding work plan.

- 2. Warwickshire North Clinical Commissioning Group and South Warwickshire Clinical Commissioning Group should ensure that:**
 - 2.1 A template and supporting guidance is available for GPs to use for child protection conferences reports.
 - 2.2 They work in partnership with the local authority and SWFT to support Looked after Children within Warwickshire receiving their initial health assessments within the statutory guidance for coming into care.
 - 2.3 They expedite the provision of appropriate health representation into the MASH with the facility to review effectiveness with partner agencies in six months.
 - 2.4 The designated roles have capacity and meet the statutory guidance and assurance framework
 - 2.5 GP practices are issued with the appropriate Read Codes using the RCGP Toolkit as a best practice guide.

- 3. Warwickshire North Clinical Commissioning Group, South Warwickshire Clinical Commissioning Group and George Eliot Hospital NHS Trust should ensure that:**

- 3.1 Notifications of attendance of children and young people from ED and CAU settings are of a good quality and give full information relating to attendance, including frequency of visits, so that concerns can be followed up effectively.
- 3.2 Effective monitoring arrangements are in place to ensure a deteriorating child in ED and CAU paediatric waiting areas are identified promptly.
- 3.3 ED documentation includes the recording of the adult's parenting/ caring role in relation to children and young people.
- 3.4 ED and CAU documentation prompts an assessment of the social history and demographics of the child and their family
- 3.5 The ED and CAU record the 'child's voice' and a process is established to give assurance is gained through governance arrangements
- 3.6 Midwives routinely ask questions about domestic abuse of expectant mothers throughout their pregnancy and answers are recorded and subject to managerial oversight.
- 3.7 Effective liaison and sharing of information is undertaken with other health professionals as a regular part of joint case management.
- 3.8 The use of the LSCB CSE screening tool is embedded in practice and subject to effective governance arrangements.
- 3.9 Integrated sexual health services are supported to identify children at risk of CSE and known to the sexual health service.
- 3.10 Routine enquiry of FGM is integrated into sexual health records
- 3.11 Allocation of women with high vulnerability ensures community midwives maintain their safeguarding case experience.
- 3.12 The records of child/ young people attending at ED and CAU are reviewed to ensure all safeguarding risks and vulnerabilities have been identified and acted on.
- 3.13 Midwifery services routinely record supervision actions within the patient's records.

4. Warwickshire North Clinical Commissioning Group, South Warwickshire Clinical Commissioning Group and South Warwickshire Foundation Trust should ensure that:

- 4.1 Notifications of attendance of children and young people from ED are of a good quality and give full information relating to attendance, including frequency of visits, so that concerns can be followed up effectively.

- 4.2 Notifications from MIU are transferred promptly to health visitors and school nurses in order that children may be supported and safeguarded effectively.
- 4.3 The recording of the monitoring of observations of children and young people waiting to be seen at Warwick Hospital ED paediatric waiting areas is implemented.
- 4.4 Adult ED records should prompt the recording of the adult attendee's parental or caring responsibilities.
- 4.5 A process is introduced to ensure school age children on child protection plans are known to the acute settings
- 4.6 The ED and unscheduled care settings record the 'child's voice' and a process is established to give assurance is gained through governance arrangements.
- 4.7 Effective liaison and sharing of information is undertaken with other health professionals as a regular part of joint case management.
- 4.8 Reports are provided for all child protection case conferences by midwives and health visitors irrespective of attendance and an assurance process monitors this activity and the reviewing of reports prior to submission.
- 4.9 Flagging systems for vulnerable children are in place and easily accessible within health visitor paper record systems.
- 4.10 The use of the LSCB CSE screening tool is embedded in practice and subject to effective governance arrangements.
- 4.11 Care and placements plans are routinely used to inform the final RHA and outcomes are included in the health passport.
- 4.12 All young people co-produce their final health assessment and receive their health passport in a timely way.
- 4.13 The expertise of the Designated LAC Dr and Nurse is utilised as part of the CAMHS transformation programme.
- 4.14 The Named Midwife has sufficient capacity to meet the needs of the vulnerable women and discharge the safeguarding responsibilities within the named midwife role.
- 4.15 Health visitor records document the parents or adults living with a child and how this has informed the assessment of risk.
- 4.16 There is an effective quality assurance process for reviewing IHA and RHA and the outcomes inform frontline practice.

- 4.17 Safeguarding competencies are explicit in the preceptorship programme for midwives
- 4.18 Midwifery services routinely record supervision actions within the patient's records.
- 4.19 There is adequate capacity to deliver and monitor health visitors accessing 1:1 supervision on complex cases within the supervision framework.
- 4.20 Supervision arrangements are established for the Designated Nurse for LAC and LAC nurse specialist, this should include recording outcomes in the child's record.

5. Compass should ensure that:

- 5.1 Reports by school nurses are provided to all child protection case conferences irrespective of attendance and the assurance process monitors this activity and the reviewing of reports prior to submission.
- 5.2 Flagging systems for vulnerable children are in place and easily accessible within electronic record systems.
- 5.3 The use of the LSCB CSE screening tool is embedded in practice and subject to effective governance arrangements.
- 5.4 School nurses Review Health Assessments action plans follow a SMART format to ensure young people's needs are met.
- 5.5 Effective liaison and sharing of information is undertaken with other health professionals as a regular part of joint case management.
- 5.6 There is adequate capacity to deliver and monitor school nurses accessing 1:1 supervision on complex cases.

6. Warwickshire North Clinical Commissioning Group, South Warwickshire Clinical Commissioning Group, Coventry and Rugby Clinical Commissioning Group and Coventry & Warwickshire Partnership Trust should ensure that:

- 6.1 Children and young people have prompt access to CAMHS therapeutic support.
- 6.2 The electronic case recording system in adult mental health supports practitioners in prioritising the safeguarding of children in line with Think Family service model.

- 6.3 Effective liaison and sharing of information by adult and children services is undertaken with other health professionals as a regular part of joint case management.
- 6.4 Reports by adult and children's mental health services are provided to all child protection case conferences irrespective of attendance and the assurance process monitors this activity and the reviewing of reports prior to submission.
- 6.5 Flagging systems for vulnerable children are in place and easily accessible within electronic record systems.
- 6.6 The use of the LSCB CSE screening tool within CAMHS is embedded in practice and subject to effective governance arrangements.
- 6.7 CAMHS and Journeys practitioners routinely inform Looked after Children's statutory health assessments.
- 6.8 Looked after children receive timely therapeutic intervention within the CAMHS commensurate with their increased vulnerability.
- 6.9 Adult mental health documentation, systems, processes and frontline operational leadership and governance arrangements are in place that demonstrates that Think Family practice is embedded.
- 6.10 Adult services safeguarding referrals are supported by an understanding of the LSCB threshold document and clearly articulate the risks and level of concern
- 6.11 Practitioners within adult services routinely record supervision actions within the patient's records.
- 6.12 Adult services operational managers are effective in their monitoring and oversight of supervision processes and practice

7. Recovery Partnership should ensure that:

- 7.1 Reports are provided to all child protection case conferences irrespective of attendance and the assurance process monitors this activity and the reviewing of reports prior to submission.
- 7.2 Practitioners routinely record supervision actions within the patient's records.

Next steps

An action plan addressing the recommendations above is required from Warwickshire North and South Warwickshire CCG's within **20 working days** of receipt of this report.

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