Review of health services for Children Looked-after and Safeguarding in Telford and Wrekin

Children Looked-after and Safeguarding
The role of health services in Telford and Wrekin

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Name(s) of CQC inspector:	Jeffrey Boxer Lucy Harte Emma Wilson Elaine Croll
Provider services included:	• Shrewsbury and Telford Hospital NHS Trust (SATH) • Shropshire Community Health NHS Trust (SCHT) • South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)
CCGs included:	NHS Telford & Wrekin CCG
NHS England area:	Midlands and East Region
CQC region:	Central
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Janet Williamson

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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 Telford and Wrekin. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

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

About the review

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

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

How we carried out the review

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

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 83 children and young people.

Context of the review

The latest published information from the Child and Mental Health Observatory (ChiMat) (2015) shows that children and young people under the age of 20 make up 25.7% of the population of Telford and Wrekin. There are 16.8% of school age children from a minority ethnic group. The proportion of children under 16 living in poverty is 23%, greater than the England average of 18.6%, whereas the rate of family homelessness is fewer at 0.5 per 1,000 as opposed to 1.8 for England. The number of children in care is also greater than the England average with 75, as opposed to 60 per 10,000. The infant (aged 0 to 1 year) mortality rate is significantly worse than England with six per 10,000 as opposed to the national average of four. The child mortality rate is not significantly different to the rest of England.

The ChiMat data shows a mixed picture for the general health of children and young people in Telford and Wrekin. Some of the attributes measured are worse than the rest of England whereas some others are better or not significantly different to the England figures. For example, immunisation coverage for all children is better than the England average with the coverage for children in care being significantly better.

However, the rates of hospital admissions for children aged 0 to 14 in the area due to injuries, hospital admissions in young people aged up to 19 for asthma and hospital admissions for young people up to the age of 24 through self-harm, are all significantly worse than the rest of England. The rate of under 18 conceptions and of teenaged mothers is also significantly worse than both the England and regional average.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2015, Telford and Wrekin had 215 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 35 of whom were aged five or younger.

The DfE data indicates that a greater proportion of Telford and Wrekin's looked-after children (90.7%) had received an annual health assessment than the average for England (89.7%). All (100%) of looked-after children aged five and under had an up-to-date development assessment, greater than the England average of 89.4%. The data also shows that 97.7% of looked-after children were up-to-date with both their immunisations and with their dental checks, higher than the England average of 87.8% and 85.8% respectively.

The commissioning and provision of health care services for children and young people in Telford and Wrekin is as follows. Commissioning and planning of most health services for children are carried out by NHS Telford and Wrekin CCG. Health services for looked-after children are also commissioned by the Telford and Wrekin CCG and provided by Shropshire Community Health NHS Trust (SCHT).

Acute hospital services, including emergency care and maternity, are commissioned by the CCG and provided by Shrewsbury and Telford Hospital NHS Trust (SATH).

Community health services for children and families (health visiting and school nursing), are commissioned by the Public Health team of Telford and Wrekin Council and provided by SCHT.

The child and adolescent mental health services (CAMHS) are commissioned by the CCG and provided by SCHT although the CCG are currently nearing the end of a project to re-commission a holistic emotional health and well-being service for children and young people which will begin to operate in 2017.

The adult mental health services are commissioned by the CCG and provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT).

Contraception and Sexual Health (CASH) and Genitourinary Medicine (GUM) services are commissioned by Telford and Wrekin Council and provided by SSSFT.

Substance misuse services are commissioned by Telford and Wrekin Council and are provided through an arrangement between the Aquarius STARS (who provide lower level interventions for less severe problems), the council-led Drug and Alcohol Recovery Service (DARS) (for more severe problems) and SSSFT under the branding 'Inclusion' who provide pharmacological and clinical support. We did not visit the child substance misuse service as part of this review.

The last inspection of safeguarding and looked-after children's services for Telford and Wrekin that involved the health services took place in June and July 2012. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for both safeguarding children and looked-after children were judged to be 'adequate'. Recommendations for the providers arising from our recommendations of that review were considered during this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in July 2016 and we have taken account of their findings during this review.

All three of the provider NHS trusts identified above have been inspected by the CQC under either the regulatory or the mental health inspection framework since October 2014. The findings of those inspections in relation to children and young people have been considered as part of this review.

The report

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

What people told us

Young people spoke to us about the CAMHS, They told us:

> "CAMHS have been really helpful."
>
> "I have weekly appointments with CAMHS and I feel listened to."

Care leavers told us of their experience of the health services:

> "When I have had my yearly medical I can talk about the plan and I would get a copy of this."
>
> "My annual health medical was in a set place like in a clinic. I've never had it done where I am staying."
>
> "Staff give me advice about my health; it's been pretty good to be honest."

Other young people told us:

> "It's easy to get an appointment with my doctor."
>
> "I think health staff listen to me."

A new parent in the Princess Royal Hospital Women's and Children's maternity unit said:

> "Our care was spot on when we came to the consultant unit."
>
> "The care I have had from midwives in the community has been ok but I had to move around to be able to access them at appointments".

Another told us:

> “I did not feel listened to when I telephoned the midwife (at the midwife led unit) and told her my contractions were a couple of minutes apart and feeling that I needed to push. My waters had already broken. I was told to stay at home.”

Another said:

> “When I went to the midwife led unit I felt I had to push. The midwife did not tell me anything at that point. I became dehydrated and was moved to the consultant unit because things had slowed down. The doctor who delivered the baby was good and the midwife was very informative. I would recommend the consultant care.”

A foster carer reported:

> “Health staff are really good, they are lovely with the children when we go for their yearly medical even with different staff.”
>
> “We are given the choice of different clinics to have the health assessments but we have never been offered one in the home.”
>
> “We did not have to wait long for an appointment for the CAMHS service.”
>
> “I have never had a problem registering children placed in my care with a GP or a dentist.”
>
> “When the children have had their health assessment I always have a copy of the plan sent to me.”
>
> “I feel listened to at health assessments.”
>
> “I feel kept in the loop about things.”
>
> “I don’t think the health services could be improved.”
>
> “I like the way they [staff completing health assessments], talk to the child they ask the child how they keep fit and healthy, and they never speak over the child to the adult. This is really good.”

Another foster carer said:

> “I’ve worked with health staff and recently had a lot of dealings with the hospital. At the end of the appointment I am given the choice of where the next appointment can be held. This helps when you have a busy schedule caring for children and needing to get to appointments.”
>
> “Recently a child in my care had (condition name) which was quite a shock. They have been signed off now though. The staff were always very good and tried to include me in what was going on.”
>
> “I was given quite a few leaflets to get information and was told about where I could get some other support.”

“I feel what could be better is the way different aspects work together. I have had experience of GPs and health visitors not having health information about children available to them as there have been delays in getting this sent.”

“Health staff are easy to contact.”

“I feel listened to very well.”

“I find that the person doing the initial looked-after child medical does not always have the child’s health history available to them.”

“Quite often after a baby is born and placed in care you don’t get a lot of information other than what is written in the red book. Sometimes there is information missing about the pregnancy such as the type of pregnancy, did it go to full term, was it a normal delivery.”

“Review health assessments for under-fives are done by the health visitor. They usually have more health information about the child as they get to see the child at other times.”

“I get copies of health action plans.”

“When children have needed physiotherapists they have not waited long.”

“On the whole I’m really quite impressed with the help you can get and how quick you get it. I think it works. They always come across that they care.”

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 Health services in Telford and Wrekin follow the Telford and Wrekin Safeguarding Children Board's (TWSCB) procedures for making referrals for children and young people for additional services according to their level of need. Those levels of need are described by the TWSCB as universal, vulnerable, complex and acute. Referrals for children whose need is described as vulnerable or complex are made direct to other local early help services such as the Telford and Wrekin Child and Family Locality Services (CAFLS) or through the multi-agency single point of access known as 'Family Connect'. Family Connect also manage all referrals for the child and adolescent mental health service (CAMHS) and all referrals for children and young people whose need is described as acute, such as the statutory thresholds of child in need or child protection.

1.2 Pregnant women can self-refer or book though their GP for their pregnancy health-care and can choose between two main pathways for their care. The first of these options is aimed at women who do not have or are not expected to have complicating features in their pregnancy or birth. Their care is provided solely by midwives from a Midwife-Led Unit (MLU) or in clinics within a small number of GP practices. Any woman with complex features in their pregnancy or with known risks will have their care provided at the purpose built women and children's centre in the Princess Royal Hospital (PRH). We learned that an increasing number of women without any complicating features, the significant majority, now choose for their babies to be delivered in the consultant-led unit in the PRH centre.

1.3 There are two 'Teenage Identified Midwives' (TIM) employed in Telford and Wrekin who have a flexible approach to caring for their clients and will see them in a range of settings. This includes the woman's home, thus increasing the opportunities to assess for any vulnerability to the young woman and her unborn child. For young women under 19 years, the TIM uses a Common Assessment Framework (CAF) approach to help plan and deliver her ante-natal care. A CAF is also completed for mothers-to-be aged 19 or 20 but focused on the needs of the unborn child rather than the woman. Since Telford and Wrekin has a significantly higher than average rate of under 18 conceptions and teenage pregnancies than elsewhere in England, this represents a strong and focussed offer to identify and meet any additional needs of this vulnerable cohort of women and their newborn babies .

1.4 There is an expectation that all pregnant women should have a home visit at 28 weeks of pregnancy. This approach helps midwives to consider the home conditions and environment to enable ongoing risk assessment and planning for the unborn child. We saw this in two cases of women who were receiving enhanced midwifery support due to their circumstances, such as, for example, a teenaged mother-to-be. However, the named midwife reported that they do not monitor or audit the achievement of this 28 week universal contact so it is not clear how well embedded this is in practice.

1.5 The named midwife attends meetings of the Multi-Agency Risk Assessment Conference (MARAC) where it is known that women who are pregnant will be discussed. This is a key contribution to information sharing and multi-agency decision making. The named midwife retains information about those women subject of the MARAC that have not yet booked their pregnancy care and alerts the booking team. This ensures that women with additional needs or at risk are identified straightaway, which helps midwives during care planning.

1.6 During the pregnancy booking process, midwives assess women for obstetric risks but also consider additional risks such as domestic abuse (if it is safe to enquire), female genital mutilation (FGM), substance misuse and maternal mental health. For example, in the case records we looked at, a routine enquiry for domestic abuse was made at booking for all but one woman; in that instance she was accompanied by her partner and it was deemed not appropriate to ask. However, there was no evidence in any records that this enquiry was made again during a woman's episode of care. Furthermore, when midwives identify domestic abuse risks they do not routinely use an assessment tool such as the Domestic Abuse, Stalking and Honour Based Violence (DASH) checklist to measure the level of risk women might be experiencing. This limits the capacity of the service to understand evolving needs arising from the risks of domestic abuse, particularly later in pregnancy, or to consider any offer of early help or support to the woman and her newborn child. ***Recommendations 1.1*** and ***1.2***.

1.7 The existing format of the booking in template on the electronic patient records system used by the maternity service does not prompt midwives to enquire about the woman's partner's mental health or their misuse of substances. We saw no evidence that midwives had explored the potential for this at the point of booking or later in pregnancy. A lack of enquiry about these issues through pregnancy weakens the assessment of potential risks to children and newborn infants at a time of significant change and stress. Further, ongoing care or discharge planning does not benefit from this insight into a woman's family life. ***Recommendation 1.3***.

1.8 There are processes in place in the health visiting service to support information flow into and out of the MARAC. The service has developed a form that is given to the named health visitor prior to the conference, which they update with relevant information. After the conference, the key risks and health action plan are recorded in the client records using the same template. This information allows health visitors to target aspects of the healthy child programme and make assessments about any other risks of home visiting.

1.9 Whilst information sharing with the MARAC is well developed, health visitors do not make a routine enquiry of their clients about potential domestic abuse. This is despite having received role specific training on this subject delivered by domestic abuse champions through a bespoke Institute of Health Visiting training programme. We heard from staff that the training had led them to feel more confident in asking questions about domestic abuse but such questions were not evident in the cases we looked at.

1.10 In one record that contained an action plan to support a woman with additional needs, there was already plentiful information about domestic abuse risks. When the health visitor made ante-natal contact there was no enquiry made about domestic abuse. This is not compliant with National Institute of Health and Care Excellence (NICE) guidelines and limits the ability to fully appraise the risk to the unborn child and to raise or escalate concerns. Further, there has been no audit of cases to identify whether the training has had an impact on practice. This means that specific needs of children arising from such risks may be overlooked. This is particularly the case since, generally, there is no up-to-date information emanating from maternity services about domestic abuse since the point at which the woman's pregnancy was booked. We have brought this to the attention of the Telford and Wrekin public health team, the commissioners of the health visiting service. ***Recommendation 2.1***.

1.11 The practice of assessing and including fathers or partners in care planning is underdeveloped within the health visiting service. The family demographic template does not support practitioners to consider significant adult men. For example, in the cases we reviewed parents' dates of birth were generally missing and there was no record made of any differences in religion or ethnicity of the parents or carers. In one case that we saw, a father had asked to be present at the visit but the only information about him that had been recorded was two pieces of insignificant personal information unrelated to his parenting capacity.

1.12 In another case two police reports in relation to domestic abuse received by the service did not trigger any contact with the family by the health visitor or liaison with other agencies. A recent local case learning review identified that all agencies must consistently recognise the importance of assessing fathers and partners in their work with families. There is no evidence from the records reviewed that this has been embedded in practice. We have also brought this to the attention of the Telford and Wrekin public health team. ***Recommendation 2.2****.*

1.13 The school nursing service has strong links and regular contact with their named schools, providing a good range of information and services for children and young people. Records we looked at showed evidence of school nurses liaising with schools to provide early intervention for children, young people and their families and we found a number of examples of this. For example, the nurses hold a school nursing assembly for reception children so parents know the service offer and how to access it. Also, all secondary schools have a weekly drop-in for advice that incorporates a sexual health service such as contraception, pregnancy testing, chlamydia screening and emergency contraception.

1.14 The school nursing service operates a referral system where children, parents and professionals can refer into the service for targeted work including advice on puberty, bullying, developing confidence, healthy eating and exercise. This demonstrates that vulnerable children and young people have access to early help and support initiatives provided directly by the school nursing service.

1.15 The school nursing service has a dual qualified mental health and school nurse who is a link for emotional health and wellbeing and a point of advice and support for other school nurses. The nurse has been instrumental in improving the quality of emotional health for children and young people in Telford for children and young people who do not require access to specialist mental health services. We have seen examples of this activity during our review, such as the work with the local authority to train staff and young person peers in schools to support other young people with emotional health needs.

1.16 The school nursing service has a strong approach to domestic abuse. This includes, for example, additional training and processes for receiving, recording and responding to domestic abuse notifications. We saw evidence of a referral being made to the local 'Impact' counselling team to ensure a young person who had experienced domestic abuse received counselling and support to help deal with the consequences of this. There was also evidence of information shared with the MARAC to inform ongoing interventions.

1.17 Liaison between school nurses and GPs should be strengthened. Some school nurses have regular meetings with their respective local GP practices but this is not consistent. School nurses do not routinely share health needs assessments or CAF assessments with the child's GP and this prevents GPs from having a full picture of a child's needs. We have brought this to the attention of the Telford and Wrekin public health team, the commissioners of the school nursing service. ***Recommendation 2.3***.

1.18 The use of the CAF is embedded within the school nursing team to help determine the need for, and to provide children, young people and families with early help. School nurses act as lead professional if identified as the most suitable and attend 'team around the child' (TAC) meetings. Two cases we reviewed showed a real, proactive commitment from the school nurse to ensure the families were listened to, their needs competently assessed and comprehensive support delivered.

1.19 The CAMHS have developed a waiting list review tool where those children and young people on waiting lists will be regularly reviewed and risk-assessed in order to mitigate any anxieties they have whilst waiting to be seen. However, this is not yet in place. The CAMHS do not currently provide support or training to other providers or disciplines in managing anxieties of young people on waiting lists, apart from some historical training previously provided to school nurses. This will be strengthened by some planned work with school nurses. The intention is to offer targeted support to young people in schools by a CAMHS worker for each school who will dedicate 'on-call' time to coincide with the school nurse service drop-ins. However, this too is not yet in place. ***Recommendation 2.4***.

1.20 The emergency department (ED) at Princess Royal Hospital have a well-established system for identifying children who might benefit from early help or additional support from universal services. This is by means of a self-carbonating safeguarding form, known as a 'green form', used by ED staff to bring young people to the attention of the Paediatric Liaison Health Visitor or the named nurse for onwards referral. The green forms are generally well completed in accordance with hospital guidance and with sufficient detail of the precipitating concerns.

1.21 However, only those children who meet certain criteria are subject of a green form and onwards referral to universal services and not every child, as is required by the Royal College of Paediatrics and Child Health (RCPCH) guidance. In addition, the Paediatric Liaison Health Visitor reviews a daily list, every morning, of attendances of children aged 0-5 and selects only those children where there are concerns. There is no other means of assuring that every child's record is subject to oversight to ensure nothing is missed. ***Recommendation 1.4***.

1.22 Furthermore, the named safeguarding nurse, and not the Paediatric Liaison Health Visitor, reviews the green forms for the 6-18s cohort and makes referrals to the school nursing service. This is an unusual arrangement, which impacts upon the named nurse's capacity. Consistent review, oversight and follow-on action could be improved by ensuring that all children's records are reviewed by one role. We have commented further on this under 'Leadership and Management' below.

1.23 The ED staff at PRH have access to an independent domestic violence advisor (IDVA) through a third sector provider and there is good reporting to MARAC. However, there is no evidence of the risks of domestic abuse being explored when an adult presents at the ED. The bespoke adult documentation, known as a 'cas-card', which accompanies a patient on their journey through ED, has a check-box with a 'Y' or 'N' response to prompt the staff to consider this. However, we did not see this completed in any of the records we looked at. One MARAC record we saw arose directly as a result of the admission of the woman due to injuries sustained through domestic abuse whereas records of other women, including women who were pregnant, contained no information about this. This may mean that opportunities to identify any new risks could be missed. ***Recommendation 1.5***.

1.24 Young people can get access to sexual health services through a booked appointment or a drop-in clinic. In the records we reviewed we saw evidence that young people are prioritised through the service's triage process and so waiting times are kept to minimum. In May 2016, the sexual health services moved to a town-centre location, which is well served by train and bus routes, making it physically more accessible to young people. Outreach clinics are also offered at two colleges where young people can access sexual health screening, treatment and contraception at a time and location more convenient to them. This increases the opportunities for staff to identify vulnerable young people and to signpost or refer them on to other services that might meet their needs.

1.25 Multi-disciplinary liaison between the adult mental health service, health visitors, school nurses, social workers, midwives and GPs is underdeveloped. Currently, adult mental health practitioners do not proactively contact other professionals when working with parents although they will share information when requested. This means that opportunities for other services to consider their role in a child's life might be missed. ***Recommendation 3.1.***

1.26 Assessment documentation used by the substance misuse team enables the identification of vulnerable children and for support to be provided. When clients first enter the service they are assessed by a duty triage worker. The assessment includes questions that identify whether the client has contact with children. The allocated key worker then completes a comprehensive child welfare assessment which incorporates a 'Supporting Families' plan. This plan provides an opportunity to identify strengths and risks in the relationship between the child and the adult. The supporting families plan takes account of who the family goes to for support, what their daily routine is, the services they have access to in the community and how they obtain and store substances. It also ensures further exploration about how the use of a substance might be impacting on the client's response to their child. From the records we looked at, we saw plentiful evidence of timely information sharing with Family Connect so as to provide early help opportunities.

1.27 As we have set out above, the relationship between GPs and school nurses is inconsistent. However, in each of the three GP practices we visited (one of which is also the walk-in centre in the grounds of PRH) we noted that there are regular liaison meetings with health visitors to discuss vulnerable children across Telford. These meetings, and actions arising from them, are sometimes noted in separate files but are also generally reflected in the child's electronic patient records. In one practice, for example, we noted that information sharing with universal services was well developed with clear processes for oversight by the practice manager and safeguarding lead. This ensures children and young people with additional needs are highlighted and directed to early help services and we saw evidence of this in records we looked at.

2. Children in need

2.1 Where vulnerable pregnant women are identified by the maternity service, there is a good process for planning and providing additional support for the mother-to-be and her baby. In such cases, risks to unborn children are discussed and monitored in a monthly, multi-agency 'Safeguarding and Supporting Women with Additional Needs' (SSWwAN) meeting. This is a midwife-led group that includes attendance from health visitors, teenage identified midwives and the family nurse partnership (FNP) with information contributed by Family Connect. Midwives bring concerns to the attention of the named midwife or the specialist midwife for mental health and substance misuse by completing a SSWwAN form.

2.2 This is a strong arrangement as it ensures a greater level of oversight for those vulnerable women identified for such intervention and enables plans to be made to support their ongoing care and the care of their newborn child. For example, health visitors can initiate ante-natal contact for vulnerable women to better prepare for their post-natal role. However, as we have set out below, the effectiveness of this is hampered by the limitations in specialist midwifery support and oversight.

2.3 Despite the SSWwAN meetings, oversight of all complex cases, and the support and guidance offered to front line, case-holding midwives for vulnerable women is limited. This function is undertaken by the specialist midwife for mental health and substance misuse, and by the named midwife herself whose capacity is affected by her dual role of domestic abuse midwife and by other competing demands we have set out under 'Leadership and Management' below. There are no other specialist safeguarding midwives that would otherwise provide this additional support and guidance and the oversight of complex cases. We acknowledge that there are also two teenage identified midwives (TIM). However, their role in the Telford and Wrekin area of the SATH footprint is limited to pregnant women under 20, unlike their broader remit in other areas of Shropshire.

2.4 There is a link community midwife for safeguarding in each community midwifery team to aid information sharing. However, this arrangement is less effective than it should be as the link practitioners are not able to consistently attend SSWwAN meetings due to other competing priorities. This places an additional burden on the named midwife to ensure that actions and outcomes that relate to women are effectively communicated to the relevant community midwifery team. The arrangement for support is further hindered by the mechanism for sharing concerns about vulnerable women with the named midwife through the SSWwAN forms. This is reliant on community midwives identifying and reporting those concerns and we learned from the named midwife that such reporting is variable. This means that some women with vulnerabilities may not have access to specialist support or their needs may be overlooked entirely. ***Recommendations 1.6*** and ***1.7***.

2.5 There is no dedicated joint substance misuse clinic for pregnant women with substance misuse problems to help plan both the care during pregnancy and the management of their substance misuse. Women are referred to the specialist midwife for mental health and substance misuse at booking and additional one-to-one support is offered throughout pregnancy by way of home visits, meeting at clinic or support by telephone. The SSWwAN approach supports information sharing when such women are correctly identified and we saw evidence of liaison between the adult substance misuse service and midwives. However, the absence of robust joint care planning to support this hard to reach cohort of women throughout their episode of care means that mothers and babies at risk do not benefit from effective joint working to secure good, measurable outcomes. ***Recommendation 1.9***.

2.6 The extent of information recorded on babies' discharge summaries is an area for development as not all of those reviewed reflected the needs of babies and their follow-up care. Strengthening this will facilitate more robust information sharing at key points where care is being transferred between professionals; for example for looked-after babies discharged into foster care or those subject of child in need or child protection plans. ***Recommendation 1.10***.

2.7 There is currently no dedicated multi-disciplinary peri-natal mental health service commissioned in Telford and Wrekin although we acknowledge that steps are underway to secure funding for just such a service. However, at present, the care of pregnant women with identified mental ill-health needs is subject of the SATH peri-natal mental health pathway. After assessment, this enables a woman to be either referred for treatment planning at a fortnightly joint obstetric and mental health clinic held in the Women and Children's Centre at PRH or to be directed to other community based services depending on the severity or complexity of her illness. Such community based services include GPs, Improving Access to Psychological Therapies (IAPT) or directed self-help therapies.

2.8 The joint peri-natal mental health clinic, which is supported by a mental health nurse from SSSFT, provides treatment and care for a woman up to six weeks post-natal, after which her care is transferred to the community mental health team or to her GP. We are advised that regular liaison and information sharing takes place between midwives and GPs and between the mental health nurse and GPs although joint care planning between midwives and GPs for such women is underdeveloped. We did not see any specific examples of this in the cases we reviewed. It was also reported that practitioners in community mental health teams have not received any specialist training in peri-natal mental health which might lead to ineffective post-natal care. However, we are aware that midwives and health visitors have all received additional training to help them to identify mental ill-health and provide emotional support. In summary, the current peri-natal arrangements are fragmented and underdeveloped. They are acknowledged by the trusts as potentially failing to deliver a timely and efficient service, the effect of which is that the needs of newborn children of women using the service might not be fully met. ***Recommendation 4.1***.

2.9 There is evidence of joint working between health visitors and children's social care to develop practice and improve outcomes for children. For example, co-ordinators attend a CAFLS forum and a Child in Need forum to discuss service developments, areas of risk and good practice or to raise concerns about a particular case. This facilitates timely sharing of information in relation to risks and a joint understanding of the application of thresholds.

2.10 A band six school nurse holds a caseload of children who are not in education or who are home educated as well as some looked-after children. The nurse works closely with the named tutor for home educated children within Telford with whom they carry out joint visits to give targeted health advice. All parents of home educated children are given details about how to access the school nursing service. At present the school nursing service do not have access to the list of all home educated children living within Telford and it is unclear how parents of such children have been informed of the school nurse offer. Therefore, there is a risk that some children with particular needs might be missed. We have brought this to the attention of the Telford and Wrekin public health team, the commissioners of the school nursing service so that this can be explored within the local authority.

2.11 School nurses continue to offer a targeted service for children attending the local pupil referral unit. All year 10 and 11 children have received a one-to-one session on sexual health advice and know how to access local services. This again demonstrates that the school nursing service have strong links with alternative education provision within the local area and recognise the increased vulnerabilities of this group.

2.12 The staffing in the ED at PRH does not meet standards set out in the RCPCH standards for children and young people in emergency care settings. The ED employs four, full-time registered children's nurses which does not provide complete coverage for each shift. This is also contrary to the recommendations of the Royal College of Nursing that stipulates that at least one children's nurse should be present at all times. We learned that all nursing staff have received intermediate paediatric life support training. However, this is insufficient to meet the minimum competence requirements which should include, for example, skills in the 'physiological and psychological developmental of children and young people' and 'managing the sick and injured child or young person'. We acknowledge that the trust is aware of this shortfall and have a recruitment plan in place, however, recruitment has been problematic and this remains a long-standing item on the trust's risk register. ***Recommendation 1.11***.

2.13 Without a bespoke paediatric ED, there is generally a paucity of child specific facilities and there is a general integration with adult facilities which is not sufficiently child-friendly. All patients entering the ED are subject to the trust's 'streaming' procedure. Some patients, including children, who do not require access to emergency treatment can be streamed into the walk-in centre or the out-of-hours GP practice, both in the hospital grounds. We were assured that this ordinarily takes place at the reception desks and is undertaken by a nurse. However, on the day of our visit, streaming was taking place at the same time as triage as there was no nurse available at reception. This means that children are not always subject of a visual assessment immediately upon arrival.

2.14 There is no separate waiting area for children prior to being seen in the triage room and children and young people and their accompanying adults all wait in the general waiting area which has no facilities for children. There is no separate paediatric triage area and children are seen in the same room as adults although there is a good system in place to enable them to be prioritised and assessed within 15 minutes of attending.

2.15 After triage, children and young people are either streamed out of the ED and directed to the walk-in centre or out-of-hours GP, or remain in ED waiting to be seen for full assessment. For children aged under 13 there is a separate paediatric waiting room which is out of sight and hearing of the main waiting area as required by the guidance. This room is well equipped for children but it is only visible through a window into the corridor between reception and the treatment area. There is no formal process for regularly observing or otherwise monitoring for a deteriorating child or the interaction between children and accompanying adults.

2.16 There is no waiting area for children and young people aged 13 and over. They remain in the general waiting area after triage and before being seen. This is not child-friendly and is unwelcoming and potentially anxiety provoking.

2.17 A separate resuscitation bay, well stocked with paediatric emergency equipment, is one of four bays in the main resuscitation area and is set aside for paediatric use. However, there is only one cubicle in the main treatment area dedicated to children, which is located adjacent to the entrance to the treatment area, although we are assured that children can also be seen in one of the separate treatment rooms. We are advised that around 15,000 children and young people are seen in ED every year and so the current facilities are insufficient to meet the needs of the young patient population. In any event, the paediatric cubicle is situated close to the busiest part of the treatment area and is not adequately, audio-visually, separated from it.

2.18 Generally, the facilities and built environment outlined in the foregoing paragraphs are not in accordance with the RCPCH guidance and do not fully meet the needs of sick children. ***Recommendation 1.12****.*

2.19 There is a good pathway for young people under 16 who attend ED with self-harming behaviours. Young people are admitted to the paediatric ward for assessment by the CAMHS once medically fit and this is in accordance with NICE guidance. The pathway for those aged 16 and above involves an assessment in ED in a discrete, comfortable room set aside for this purpose (or in an adult medical unit) by the rapid assessment, interface and discharge (RAID) team in consultation with an on-call CAMHS psychiatrist.

2.20 Ordinarily the assessment of a young person in an adult environment by an adult mental health service would not benefit the young person. However, in one record we reviewed, we noted that the assessment by the RAID team was completed to a good standard, was very detailed and young person-focused and had a clear sense of the person's specific needs. The system would benefit from formal quality monitoring or oversight by the CAMHS to ensure that all assessments of young people aged 16 and 17 by this adult service are of an equally high standard. ***Recommendation 5.1***.

2.21 The CAMHS transformation plan for the service includes an intention to develop their crisis pathway for young people coming into acute settings to provide more enhanced coverage. It is also intended to provide a better, more young person-focused service than is currently provided by the RAID team for young people aged 16 and over although we have already commented on the efficacy of the RAID team in this regard above. Currently the CAMHS provides an on-call 24 hour psychiatrist to support paediatric staff but also an in-hours (nurse) duty clinician cover for all hospital call-outs. This ensures young people have timely access to psychiatric assessment.

2.22 Transition for the small number of young people who will move from the CAMHS into the adult mental health service is currently managed from age 17 and-a-half but no appointment with the adult service is offered until 10 days after the young person attains 18. We have been assured that the CAMHS will keep working with a young person for a short time until they are ready to move in to adult services although we did not see any specific cases where this was evident during our visit. In any event, the transition offer is not strong as there is no scope for joint work or planning with the adult service before the young person reaches their 18th birthday and this causes unnecessary delay. ***Recommendation 8.1***.

2.23 In the adult mental health service, the electronic patient record does not effectively support practitioners to 'Think family'. The front demographics page does not have a section to record children of clients to easily alert staff and to consider how this will affect their approach. The initial assessment documentation has a very detailed section on the client's family which prompts practitioners to consider children and any safeguarding concerns. However, this is somewhat hidden within the records and was only completed in one of the eight cases we reviewed. This means that for those other cases, the needs of families or children of clients were not fully considered during assessment or care planning. ***Recommendation 3.2***.

2.24 The electronic database in the adult mental health service flags adult records with a 'child safeguarding' alert if there is a known child protection plan or if adult mental health workers have made a safeguarding referral. However, there is no flagging system for adults with children subject of a child in need plan or living with domestic abuse and this is a missed opportunity. This limits the ability of staff working with clients to fully understand additional levels of need within a client's family. ***Recommendation 3.3***.

2.25 In the adult substance misuse service we found evidence of clear communication with clients who were parents explaining how information about their children would be shared if any concerns or additional needs were identified. Confidentiality and information sharing agreements were signed at the triage stage of assessment making clear that any issues which might not fulfil the harder to reach child protection threshold can still be shared with relevant professionals. The effect of this in records we looked at was to ensure there were no issues with sharing information and that clients had remained properly engaged with the service.

3. Child protection

3.1 As previously set out above, the multi-agency single point of access known as 'Family Connect' receives referrals from all services in Telford and Wrekin and sometimes from members of the public direct. These arrangements, usually referred to as a multi-agency safeguarding hub (MASH), enable information to be collated by a multi-disciplinary team who are co-located and decisions to be made about the most appropriate level of intervention. The health services' contribution to this process is by way of two health visitors supplied by SCHT. The health visitors in Family Connect assist the initial screening process with accurate identification of children, young people, their families and their demographic information through searches on the NHS central database. This helps the Family Connect safeguarding advisers and their team leaders to prioritise referrals according to a red-amber-green (RAG) rating or to direct cases to early help services.

3.2 For referrals that are more complex, the health visitors collate information from other health services through either direct access to electronic patient records systems or readily accessible contacts in the provider organisations. This is generally done by way of a comprehensive multi-agency check enquiry (MACE) with the hospital and community teams, the CAMHS, adult mental health and GPs. We were advised by the Family Connect social work team leader that the information from health providers, either in response to a MACE or within an initial referral itself (a 'request for service' form), was of a high standard and supported good decision making. In our review of cases within Family Connect we saw that this was generally the case with plentiful detail in either MACE or request for service forms albeit that most contained facts as opposed to analysis of risks.

Good practice example

The Health visitors in Family Connect do not simply act as data gatherers, so often a weakness in similar arrangements elsewhere. They participate actively in decision making through twice-daily scheduled triage and case consultation meetings with the rest of the multi-disciplinary team. At these meetings, information contributed by health services and summarised by the health visitors enable the Family Connect team leaders to accurately determine whether a more complex case should be directed to early help services, or allocated to a social worker for an assessment as a child in need or a child protection matter. These are strong arrangements as they make good use of the skills and experience of the health visitors employed in Family Connect, ensuring that children and young people's health information is properly understood.

3.3 The health visitor role currently has 0.8 whole time equivalent coverage and so on Friday of every week the data collection from other health services is carried out by a health visitor who staffs the health visiting duty line. This means that for one working day every week the Family Connect service does not benefit from the insight and contribution of health practitioners during the daily meetings and this is a gap. ***Recommendation 2.5***.

3.4 The electronic patient record system used in the maternity service has highly visible alerts for safeguarding concerns. This ensures that all practitioners using the record are informed of potential risks to support their ongoing delivery of care each time the woman is seen. However, we saw variable standards of record keeping by midwives with some records showing a lack of professional curiosity. For example, one record made by a midwife in a SSWwAN referral described the woman's relationship with her partner as 'volatile'. There was no clarification as to what this meant and no evidence that it had been explored further to determine the level of risk to the woman or her unborn child. ***Recommendation 1.13***.

3.5 We looked at two referrals made to children's social care from maternity services that contained appropriate safeguarding information. One referral had more detailed content than the other but both lacked analysis of the impact of the concerns on the unborn child and did not set out clearly what action they felt children's social care ought to take. ***Recommendation 1.13***.

3.6 We also saw case records where two safeguarding entries made in records by the named midwife had not been entered contemporaneously. This delay in making an appropriate entry was recorded as being due to 'workload pressures'. This does not meet with professional record keeping standards and could lead to up-to-date information not being available to a future user of the record. ***Recommendation 1.14***. We have discussed further in 'Leadership and Management' below our concerns about the named midwife's capacity.

3.7 Midwives are reported to be engaged in safeguarding work and attend child protection meetings. However, we are advised that workload demands mean that midwives attend only 80% of initial child protection conferences. For 20% of cases midwives do not participate in effective multi-agency decision making that relates to women in their care although the trust do not currently monitor attendance rates. The named midwife receives all invitations to initial child protection conferences to her email account. This is then disseminated to the relevant community midwifery team. However, in the event of the named midwife being on leave from the workplace there is a risk that this information may not be accessed thus further preventing midwives from attending. ***Recommendation 1.15***.

3.8 The named midwife attends all child protection strategy meetings for unborn babies and if she cannot attend this task is delegated to another midwife. This ensures that information is shared appropriately. However, care plans and pre-birth assessments for women and their unborn children who are subject of child protection processes do not routinely get shared with the midwives by children's social care. As a means of mitigating this, the named midwife creates interim safeguarding plans to support effective safeguarding care of women and the unborn or newborn child until a formal plan has been provided by children's social care. This ensures that midwives have access to a safeguarding plan should the woman present requiring care.

3.9 An inappropriate culture appears to have evolved as accepted practice in the maternity unit for unborn and newborn babies who are being considered for legal proceedings. This culture sees the delayed discharge of well women and babies for non-medical reasons; this is not acceptable practice and does not benefit a woman or a baby if the infant is removed shortly thereafter. In records we looked at, birth plans completed by the social worker state that the baby and mother should remain on the ward for five days. Midwives are required to monitor the babies' development and observe and report on parenting using an assessment tool. These instances should be very rare, not routine, and the maternity service is neither challenging children's social care about this arrangement nor escalating these instances as significant incidents. ***Recommendation 1.16***.

3.10 A flagging system is used by the Health Visiting team to enable identification of children who are the subject of a child protection plan or who become looked-after. The flags are dated to aid health visitors to see how children and young people may have moved through different services or into the care system. This helps to easily identify vulnerable children within a practitioner's caseload and supports the management of risk.

3.11 Health visitors attend strategy meetings for referrals that emanate from the service if there is no health representation from Family Connect available. However, in records we looked at we noted that outcomes of strategy meetings were not always made in the paper records used by the service. This is not compliant with established record keeping guidance and the absence of key information could lead to drift in cases where children are at risk. ***Recommendation 2.6***.

3.12 Health visitors attend and contribute to initial and review child protection conferences. However, the time scales for report writing do not support partnership working with families as there is no opportunity to share the report prior to conference. The letter taken to initial child protection conferences and the health needs assessments used for review conferences simply set out a summary of work with the family. They do not effectively articulate risk or the impact of parental behaviours on the child although this is principally due to the format of the letter, which does not encourage practitioners to consider this risk. ***Recommendation 2.7***.

3.13 We found evidence of appropriate escalation to children's social care although the effectiveness of communicating outcomes of the escalation process is less clear. For example, in one record we saw, the health visitor was not satisfied that the risks to all of the children in a household had been addressed; there were two children subject of a child in need plan and one subject of a child protection plan. Escalation procedures included the completion of an internal Datix report which raised the concerns with the trust's named safeguarding nurse. The named nurse then escalated the case to the children's social care manager. From that point it was referred back for discussion to a social care locality forum that has some scope to review challenging cases. The outcome of the locality meeting's review was not shown on the health visitor record and the escalation process appeared to have been discontinued. It is important that outcomes of escalated cases are followed up and clearly recorded so that any future practitioner has clear insight to support them in managing any risks. ***Recommendation 2.6***.

3.14 Child protection plans are not used to inform health visiting practice as they are not always available within the records. Minutes from child protection conferences are sent through a secure email to the practitioner who attended. The email automatically deletes after 30 days. This means that if a practitioner is absent there is no opportunity for a covering worker to view the minutes and so there is a risk that actions from conference may not be followed up. ***Recommendation 2.8***. We have brought all the above issues to the attention of the Telford and Wrekin public health team, the commissioners of the health visiting service.

Good practice example

The strong sexual health offer from the Telford and Wrekin school nursing service enables effective identification of risks of child sexual exploitation (CSE). All children attending the sexual health drop-in service are routinely screened for risk of CSE using a trust-wide tool. School nurses provide information and receive updates from the safeguarding nurse for all children being discussed at the Children Abused Through Exploitation (CATE) meetings. This helps to guide their practice and monitor risks with young people they see regularly and we saw evidence of this in records we looked at.

3.15 Despite capacity being reportedly stretched, school nurses attend all child protection conferences and core group meetings where there is a defined health need. In three cases we were tracking across services, we saw that school nurse records all contained child protection plans and minutes of conferences. This shows active engagement in the process and demonstrates that each practitioner has good insight to support the management of risk for individual children and young people.

3.16 All children subject of child protection processes have a comprehensive health needs assessment for child protection conferences which considers physical, emotional and social health needs and parenting. There is a section for school nurses to summarise and analyse their concerns. In our review of records we saw that this was consistently used with strong evidence of the 'voice of the child'. The health assessments are used to inform reports for review child protection conferences although the quality of information in the letter used for the initial child protection conference report is variable. As with the letters used in the health visiting service, the format does not encourage practitioners to consider the analysis of risk and this does not support decision making at conference. ***Recommendation 2.7****.*

3.17 Referrals made to Family Connect by the school nurses are of a good standard with sufficient detail for social care to make an informed safeguarding decision. The trust's named safeguarding nurse has oversight of all referrals made by the school nursing team through the submission of an internal Datix report. School nurses use the threshold guidance to support their referrals and clearly articulate the impact of the concerns on the child. However, school nurses are not always informed of the outcomes of referrals.

3.18 Furthermore, although we were advised that concerns are escalated in writing to children's social care when referrals do not meet the higher intervention threshold and where school nurses still have concerns, we did not see any evidence of this in our review of cases. ***Recommendation 2.6***. We have brought all the above issues to the attention of the Telford and Wrekin public health team who commission the school nursing service.

3.19 In the ED at PRH there are alerts on the electronic patient records system for children subject of a child protection plan, vulnerable children (generally used for CSE), looked-after children and children who are missing from home. Information from alerts is entered by the receptionist onto the paper record referred to as the 'cas-card'. This enables practitioners to be aware of historical or current concerns prior to examination.

3.20 There are three separate cas-card formats in use in the ED; a generic document to record information and clinical notes for patients aged 18 and over, an older person's document for patients aged 70 and over and a paediatric cas-card for children and young people aged up to 17. The paediatric cas-card has bespoke sections to record relevant information. This includes, for example, the identity of the person who the child attends with; whether there are known alerts; the number of previous attendances in the last 12 months; child-specific reference data for clinical observations and the appropriate response according to a red-amber-green (RAG) rated level of concern.

3.21 Importantly, the cas-cards include a safeguarding checklist which requires the examining clinician to consider key features about the child's presentation to inform an assessment of risk. This includes whether the history given is consistent with the clinical presentation; the appropriateness of the presentation for the child's age and whether there was any delay in presentation. Wherever we have seen checklists such as this we have found them to be generally supportive of staff in identifying matters of concern as they prompt professional curiosity. The paediatric cas-card in use at PRH is a good example of such a form although it might be strengthened further by the addition of a section to record competence of the child to consent in their own right and a prompt to ensure that where appropriate the child has an opportunity to give their own history.

3.22 However, although the cas-card is intended to support good safeguarding practice, our review of records showed that its application is ineffective. For example, there were gaps in information about significant people in the child's life or who the child attended with in nearly all of the records. The safeguarding checklist was not completed in most of the cases we looked at and completed inaccurately in two of the cases. This indicates that the importance of such key information is not well understood by staff, which means that risks, or even potential abuse, may not be identified properly. ***Recommendation 1.17****.*

3.23 Further, the adult cas-cards do not contain any tools to support staff to 'think family'. This means that staff are not prompted to identify any children that patients might have access to. In the adult's records we reviewed we found many gaps in information about children and others living at home for those presenting with risky behaviour. This shows that staff are not professionally curious about identifying children and young people and cannot therefore, consider the impact of such behaviours on their families. ***Recommendation 1.18****.*

3.24 In the cases we looked at in the ED at PRH we noted that referrals are made by ED staff to Family Connect when concerns are identified. These referrals are generally of a good standard with relevant information and risk factors articulated well in the section for 'reason for referral'. This helps practitioners who receive referrals to understand the risks to children and young people in the context of their clinical presentation.

3.25 In the CAMHS, the standard of record keeping is variable. Generally, the level of detail is high if a little descriptive (as opposed to analytical) although some records were short of such detail. For those cases we looked at where there were safeguarding concerns, however, it was clear from the records what those concerns were. ***Recommendation 2.9****.*

3.26 Referrals made from the CAMHS contain sufficient detail about risk and support effective decision making in Family Connect. We found, though, that there is no monitoring of the quality of outgoing referrals and no tracking of the outcomes of those referrals. We acknowledge that a staff member who has recently taken on the role of safeguarding link is in the process of developing processes for this, but the current arrangements for making referrals do not enable effective management oversight. This means that practitioners do not have support in managing any risks to their clients. ***Recommendation 2.10****.*

3.27 Risk assessments for CSE in the CAMHS are of a good standard and are detailed. However, in one case we reviewed there was an appreciable delay of about two months between the initial risk being identified and the referral being made to the CATE process. Even though it was clear police and Family Connect were already involved the referral ought to have been made straight away to ensure that those who need to make decisions about risks are fully apprised of all current information. ***Recommendation 2.11***.

3.28 The CAMHS staff attend both initial and review child protection conferences and a report is sent but only if requested. Whilst the records we looked at show attendance and the contribution of practitioners at conferences, this is not always supported by written information. This is particularly important for review conferences as it provides an overview of work undertaken with the child or young person and an evaluation of the impact of that work on the planned outcomes of the child protection plan. ***Recommendation 2.12***.

3.29 In common with the CAMHS and the community child health services, the sexual health service report that they are not routinely informed of the outcomes of referrals they make to children's social care. This is a gap because it means that practitioners are not supported with information that would help them to manage any risks to their clients. ***Recommendation 3.4***.

3.30 We saw variability in reviewing or repeating risk assessments when clients return to the sexual health service for follow-up appointments. For example, in one case when a children's safeguarding referral had been made after initial contact with the service, the client continued to engage with screening appointments for two consecutive months. The precipitating risk was not reviewed, neither was the outcome of the Family Connect and police referral followed up. This means that practitioners are not in a position to take account of any risk that might still be prevalent or that might have evolved. ***Recommendation 3.5***. We have brought all the above issues to the attention of the Telford and Wrekin public health team who commission the sexual health service.

3.31 At first contact, sexual health practitioners complete a holistic, child-centred assessment, including a detailed description of the young person's presentation and demeanour and the full name and relationship of the person they attend with. This is good practice as it helps build a clear picture of the young person's situation, which supports decision making.

3.32 We saw that the sexual health service are generally effective at identifying potential abuse and are timely in their response to concerns. This was evident in one particular case when a young person aged 14 reported a recent serious sexual assault. We saw that the practitioner immediately liaised with the trust's safeguarding advisor, the sexual assault referral centre, children's social care and the police. Prompt action and an awareness of professional responsibility meant that appropriate professionals were involved to ensure the incident was investigated properly and the risk of any further harm to the young person was reduced.

3.33 There are, however, inconsistencies in practice in identifying specific risks of CSE. In one record we reviewed for another young person aged 14, we noted a number of significant risk areas that had not been explored or identified when she presented for her first consultation. A CSE risk screening tool was not used to assess the risk to the young person and a safeguarding referral was not made, although this has since been rectified. We are aware that the service has recently undertaken some additional training in CSE which was ongoing just prior to and at the time of our visit and this training programme may address these inconsistencies. ***Recommendation 3.6***.

3.34 The sexual health services have a positive working relationship with the CATE team. We consistently saw evidence of the CATE team making appointments and attending sexual health services with young people. This is encouraged by the sexual health workers as it aids them in understanding the risks to the young person and supports partnership working. However, although sexual health services are invited to attend the CATE meetings they have, as yet, not had sufficient staff capacity to attend. This is a missed opportunity to add specialist knowledge and insight to the multi-agency processes to protect young people from CSE. ***Recommendation 3.7***.

3.35 The sexual health service do not consistently use alerts on young people's records to inform their practice with individual clients. This means practitioners are not immediately alerted to known risks when young people attend for follow-up appointments. There is no prompt to support practitioners to consider FGM. Whilst the team would be expected to use the NHS England FGM toolkit, it is not routine practice to explore FGM with service users who may be at risk. The team have not received FGM training and this could limit development of safeguarding practice in this area. ***Recommendation 3.8***.

3.36 In the cases we reviewed in the adult mental health service where practitioners had identified safeguarding concerns we noted that the referrals were of a good standard, giving sufficient detail for social care to make an informed decision. Each referral considered risk and clearly stated the impact of parental mental ill-health upon the child.

3.37 In eight cases reviewed in the adult mental health service there was no evidence of practitioners being actively engaged in child protection conferences. There was no evidence of written reports for conferences or attendance at core group meetings and there were no copies of child protection plans in records although it was clear that practitioners will share information if requested. In four of the records it was documented that there was a children's social worker involved with the family but there was no further exploration from the practitioner to find out about the extent of the involvement or the existence of a child protection plan. ***Recommendation 3.9***.

3.38 Furthermore, the current policy for patients who do not attend their appointments or meetings with the service does not direct staff to ensure social workers are contacted when adults fail to attend if their children are subject to child protection plans. This is a gap in the ability of the service to proactively share information with children's social care. ***Recommendation 3.1***.

3.39 Risk assessments are not consistently completed in adult mental health. We saw two cases where identified adults clearly posed a risk to children but this information had not been considered as part of the assessment; we brought these cases to the attention of managers so this could be addressed. There was also no evidence seen that risk assessments or relapse indicators are routinely shared with other agencies when safeguarding concerns are clearly present. There is a general over reliance on social workers assessing risk rather than adult mental health workers being regarded as an integral part of the process. ***Recommendations 3.1*** and ***3.2***.

3.40 Substance misuse practitioners cannot be assured that prescribed medication is being stored safely at client's homes. It is not part of routine practice to conduct a home visit to review how prescribed substances are being stored. If clients store methadone at home, they are given a lockable container and a demonstration on its use. Trusting the parents or carers to use the storage box without having a monitoring system in place may be too optimistic and mean that risks are not prioritised or fully understood. ***Recommendation 3.10***. We have brought this to the attention of the public health team at the local authority who commission this service.

3.41 Adult substance misuse services contribute to child protection conferences and core group meetings and provide reports when they are unable to attend. From the records we reviewed, the reports clearly stated how the service users' substance misuse and engagement was impacting on the child. The written report also documented the practitioners' recommendations as to the level of risk to the child and this supports good multi-agency decision making.

3.42 Child protection practice in GPs is variable in the three different practices we visited. For instance, in one practice there are very well developed processes for managing information about children and their families through efficient administrative processes. The GP safeguarding lead completes all child protection conference reports using the pro-forma supplied by children's social care for this purpose and is released from medical duties to be able to fulfil this role. The completion of reports and receipt of minutes is monitored by support staff on a spreadsheet. This allows opportunity to review previous child protection plans and identify drift.

3.43 In others practices these processes are less well developed and there is a risk that some key information may be overlooked. For example, in one practice not all children with child protection plans have the appropriate flag on their records which means the examining GP or practice nurse does not have the benefit of a full history to guide a consultation. Oversight of the flow of information prior to and after child protection conference is underdeveloped with referral forms and child protection conference documents not being uploaded to the system. This means that the information is not accessible to any other GP practice using the same records system. ***Recommendation 6.1***.

3.44 The walk-in centre in the grounds of PRH, which is also a GP practice, uses an alert system to ensure staff are aware of risks to young patients. With the agreement of Telford and Wrekin council, the named safeguarding nurse at the hospital passes on information about children who are subject of a child protection plan, women who are subject of a MARAC and other children who are identified by the hospital as being at risk. The walk-in centre then creates a separate record on their electronic patient records system and flags this with an alert. This is a pragmatic but effective means of highlighting to staff any child or young person at risk who might be streamed into the service from the ED.

Good practice example

One of the GP practices uses an amber alert for children who would benefit from extra vigilance from staff. For example, we saw an amber alert for a baby whose mother had pierced the baby's ears at the time of the new birth visit. When the mother booked in for the six to eight week baby review and post-natal examination, she and her baby were booked in with the safeguarding lead. This meant that the mother and child were seen by the doctor most equipped to consider any risks.

3.45 In the walk-in centre, we saw that all correspondence from the local authority about child protection processes was kept in a separate hard copy folder, including invitations to, and any reports made for conference. None of the documents were scanned into the patients' electronic record. As above, this means that patient records are incomplete and that the information is not accessible to any other practices. ***Recommendation 6.1***.

4. Looked after children

4.1 All paper records we reviewed for looked-after children had good completion of demographic details including ethnicity, religion and language. This supports practitioners in planning for and providing culturally sensitive care.

4.2 All looked-after children's initial health assessments are carried out by the community paediatric team. Three of the four initial health assessments we reviewed contained limited parental health history. Where this information was present, the future implications for the child or young person arising from parental health and family history had not been considered. For example, in one record we noted significant levels of domestic abuse and neglect in respect of a child who had been a carer for a mother with severe epilepsy. There was no evidence that either the child's physical or emotional needs arising from this history had been considered during the assessment. ***Recommendation 2.13***.

4.3 In initial health assessments, the 'voice of the child' and information about the presentation of the child and the child and carer interaction is not well developed. Upon reading the initial health assessments it was difficult to get a sense of the child and if, or how they had been involved in the health assessment. Further, it was not always clear who was present during the assessment, their relationship with the child or if the child had been offered the chance to be seen alone. We also saw no evidence that consent was gained from children old enough to give their own consent. This enables young people to have some control over their own health matters and is increasingly important as they spend longer in the care system and approach young adulthood. ***Recommendation 2.14***.

4.4 Review health assessments completed by the looked-after children's nurse, health visitors and school nurses are of a good quality. Seven review health assessments we looked at showed that previous health recommendations had been considered. Young people's thoughts and feelings about their own health were described through the use of direct quotes. There was also evidence of comprehensive development assessments and informative descriptions about the children and young peoples' interaction with their foster carers. There was a real sense of the child and of their involvement in the process and this is a strength.

4.5 The quality of health action plans derived from both initial and review health assessments is variable and an area for further development. Those completed as part of a review health assessment are generally of a better standard than those arising out of the initial health assessments. However, we consistently found that actions within plans were not time-bound and had not identified a person who was accountable for actions. Further, the action plans did not always reflect what was written in the health assessment. This could lead to drift with looked-after children having to wait longer than necessary for actions to be taken to maintain or improve their health. ***Recommendation 2.15***.

4.6 There was limited evidence of GPs contributing information to the initial or review health assessments and this is recognised by the looked-after children team as a gap. The designated doctor has updated all GPs on their responsibilities to looked-after children and continues to communicate with GPs about their role. Currently, however, looked-after children do not benefit from health action plans that have been supported by information about their general health from their primary care provider. ***Recommendation 7.1****.*

4.7 As a recommendation from the previous safeguarding and looked-after children review in 2012, the local authority introduced a 'leaving care passport'. This was issued to young people leaving care to support their independent management of their own health needs. We learned that the supplies of this passport have now run out and so it is no longer being issued. There is no indication if this passport will be reintroduced and so care leavers do not currently have access to their health histories in a format that can be used in a meaningful way. ***Recommendation 2.16****.*

4.8 We saw evidence of Strengths and Difficulties Questionnaires (SDQs) being used in review health assessments although the SDQs had been completed by foster carers. None of the assessments we looked at contained SDQs completed by the child or young person. This is another lost opportunity to gather key information that benefits care planning or to include, or promote the involvement of young people in discussions about their emotional health and wellbeing. ***Recommendation 2.17****.*

4.9 Although support for the emotional health and wellbeing of looked-after children has been built into the new service specification for the retendered CAMHS, the current offer for looked-after children by the CAMHS is poor. There is no dedicated looked-after children CAMHS practitioner, and this manifests itself in a number of ways. For instance, referrals to CAMHS for looked-after children are made direct by the young people's social workers to Family Connect. There is an over reliance on the social worker providing all historical information on a CAMHS referral rather than the health services communicating with each other to ensure the child's holistic health needs are met.

4.10 Following referral to Family Connect, CAMHS referrals are triaged by a CAMHS practitioner and prioritised according to the level of risk defined by certain criteria. The fact that a child or young person is a looked-after child is one of a number of criteria that can be considered as contributing to the triage risk assessment and not necessarily reason enough on its own to merit a young person being prioritised. This is contrary to the relevant guidance and means that looked-after young people who are already vulnerable may experience unnecessary delay in being assessed by CAMHS. ***Recommendation 2.18****.*

4.11 This shortfall is further evident in initial health assessments where the emotional health assessments were very limited. Even if a child has a mental health diagnosis and treatment is being provided there is no written record of emotional health needs. This is due to a historical arrangement where the CAMHS do not routinely share information with the looked-after children team. For example, in one case a young person had a CAMHS review two days after their review health assessment. The outcome of the CAMHS review was not shared with the looked-after children service and there was an acceptance by the staff that it would not be shared; therefore, neither assessment influences the other. This is an ineffective, process-driven arrangement which is not focused on the needs of the child. ***Recommendation 2.19***.

4.12 School nurses in Telford have all recently been trained to complete review health assessments and this new arrangement is due to begin shortly after our review. This will enable the child or young person to be offered a choice of venue for their health assessment, including at home, and this will benefit the child. The school nurses will also be routinely using their CSE risk assessment tool as part of the review health assessments and this will enhance the understanding of their needs. It is planned for the named nurse to offer support and advice to the school nursing team, including quality assurance of the school nurse-led health assessments. It will also allow the named nurse to concentrate on her operational, quality monitoring role and the health assessments of those children with complex needs. As this was not yet in place at the time of our review we are unable to assess its impact although we acknowledge that this is a positive and significant step.

5. 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 CCG has a highly visible safeguarding presence within the health economy in Telford and Wrekin and the local authority. For example, as we have outlined below in 'Governance', the senior nursing team are actively engaged with the TWSCB and its sub-groups. In addition, the designated nurse for safeguarding chairs the Child Death Overview Panel for Telford and Wrekin. The designated nurse is available to give advice and guidance to the named professionals in the provider organisations and is regularly called upon to deliver this. The designated nurse is also the vice chair of the newly formed NHS England Designated Professionals Network which will add to the capability of the CCG to ensure up-to-date good practice is disseminated to Telford and Wrekin health providers.

5.1.2 Internally the CCG are instrumental in ensuring safeguarding practice is regularly reviewed and improved upon. For example, we have reviewed the records of the paediatric peer review meeting held at SATH four-weekly and led by the designated doctor. The meetings are for all front line clinicians in SATH and on each occasion several safeguarding cases arising in the previous four weeks, including child protection medicals, are brought for discussion and peer review of the clinical action. This ensures that good practice is shared among medical staff and that the response to potential safeguarding cases is improved.

5.1.3 The executive lead nurse for safeguarding in the CCG and the named GP carry out joint annual visits to GPs. This is part of a quality monitoring approach where various attributes of safeguarding performance in practices are measured; such as the use of alerts in the electronic patient records system, relevant child protection paperwork is held in patient notes and the presence of safeguarding information on notice boards. The visits also allow GPs to discuss cases they have been dealing with in order to sense-check their actions and ensure their processes are in order. Ostensibly, this is a strong arrangement as it enables the CCG to have first-hand knowledge of safeguarding performance within GP practices as opposed to being over reliant on audit reports. It also helps to promote with GPs the availability and accessibility of the CCG for safeguarding advice and guidance. However, the variability in practice we found in the GPs we visited, and which we have reported under 'Child Protection' above, would suggest that this monitoring process is not yet as effective as intended.

5.1.4 Historically the designated nurse role for looked-after children has been shared between two post-holders within the SCHT, the provider of the service, and not with the CCG. There have been no provider based roles in place that would ordinarily be described as named nurse. There are risks to this arrangement since the strategic, cross-provider commissioner facing responsibilities of the designated role can be at conflict with the provider facing responsibilities of the named role. The Telford and Wrekin CCG and the Shropshire CCG have acknowledged this and steps are underway to realign the role of designated nurse.

5.1.5 We note that there has been a delay in this realignment and in recruiting to the post. This delay has been compounded by the retirement of a key member of staff. This has left one post holder covering both the designated role and a role in the provider service that would usually be described as the named nurse, whilst having to complete the clinical element of all review health assessments for the 5-18 years cohort. We acknowledge that this is about to be resolved imminently with the appointment of a new designated nurse within the CCG and by the newly enhanced role of school nurses who will carry out review health assessments. However, currently, quality monitoring is not taking place due to the sole looked-after children nurse focussing entirely on health assessments. ***Recommendation 6.2****.*

5.1.6 The named midwife currently has a limited impact on the strategic development of safeguarding practice in Telford and Wrekin. This is as a consequence of competing operational demands that are being prioritised. For example, the named midwife is not able to contribute to the neglect and domestic abuse LSCB sub-groups that she is aligned to due to her role in providing operational safeguarding oversight in the consultant-led unit at PRH, the five midwife-led units and the two other community midwifery teams across Shropshire. There are no dedicated clinical safeguarding specialists for each site as recommended by the intercollegiate guidance. We have already reported under 'Child Protection' above where 'workload pressures' are recorded as being the reason why late entries are made in certain records where safeguarding advice has been given and this is evidence of the stretched capacity of named midwife. ***Recommendation 1.7****.*

5.1.7 Caseload sizes for community midwives exceed recommended levels with average caseloads of between 100 and 150 for each midwife as opposed to the recommended level of 96. Pregnant women have a range of needs that necessitate the provision of additional support. We have reported earlier of the challenges faced by link safeguarding midwives in completing their safeguarding work, such as attending SSWwAN meetings, due to competing priorities. This problem is also faced by community case-holding midwives, which is as a consequence of their limited capacity. Whilst this, too, is on the SATH risk register it is not clear what action managers have taken to support community midwives to manage their increased caseloads safely and effectively. ***Recommendation 1.8****.*

5.1.8 We learned that the directorate leadership team have been made aware of the challenges to effective safeguarding work within the maternity service and these are reportedly held as risks on the SATH risk register. These are, safeguarding supervision, the capacity of community midwives to undertake safeguarding work and the delivery of the named midwife role. However, it is not clear what actions the trust has taken to effectively minimise these risks and any impact on women in their organisations care or their staff. ***Recommendations 1.6, 1.7*** and ***1.8***.

5.1.9 There are four different record keeping approaches used by the maternity service that captures and contains information about women's care. None of these approaches provide midwives with a complete record of women's care or identified risks. Midwives are required to navigate between the Medway electronic record, the paper based hospital record, any community midwifery held record and the patient-held record to locate appropriate information. We learned of occasions when women's hospital paper records had not contained child protection documents such as reports, minutes and plans following child protection conferences because there are delays in filing them in the most appropriate record. This is hampered further as these important child protection documents cannot be uploaded to the electronic record. As a consequence there is a risk that important child safeguarding information is not visible or easily accessible to inform ongoing care and planning. ***Recommendation 1.15***.

5.1.10 The health visiting team have implemented a single administrative email account to receive all invitations to child protection conferences. This enables effective management oversight of staff engagement with the child protection process and assures attendance by a health visitor.

5.1.11 However, the use of audits is underdeveloped in the health visiting service, which means that managers cannot be assured of the effectiveness of common practices such as receipt of child protection conference minutes, the impact of training and the use of routine enquiry questions at core visits.

5.1.12 Capacity in the health visiting service has been a challenge owing to long-term staff absence across Telford and Wrekin. The service has taken a pragmatic approach to ensure risks are minimised by arranging cover between the three health visiting clusters. However, this will require close monitoring to ensure the safeguarding function remains effective.

5.1.13 Capacity within the school nursing team is also a concern. The band-six nurses are each allocated two secondary schools and six to eight primary schools. Whilst this enables each school to have an identified nurse, the corresponding high number of child protection cases increases risk and limits their capacity to carry out their core functions. This is recognised by SCHT and is currently on the trust risk register. Despite this, school nurses attend all child protection conferences and core groups where there is a defined health need. ***Recommendation 2.20***. We have drawn this to the attention of the public health team of the local authority as commissioners of this service.

5.1.14 The health visiting service, school nursing service and family nurse partnership pool administrative resources to manage the allocation of domestic abuse reports from the police. Currently, the team receive all police notifications for Shropshire as well as Telford and Wrekin. This is beneficial because key information for each community service can be held in one place, and is accessible by each service. However, it was reported that the high numbers of notifications, up to 60 each day, is proving to be a significant challenge to the administrative resource. ***Recommendation 2.21.***

5.1.15 The current, predominantly paper record keeping system in use in the services provided by SCHT does not enable practitioners to have access to a single complete record for children and this can lead to drift. For example, the paper records used in CAMHS are bulky and hard to navigate which makes safeguarding information difficult to retrieve. There are also no alerts on the front of files. Although the records are complete with relevant information it was time consuming to isolate safeguarding information. There is a plan in place for early 2017 to transfer all the services to a common electronic records system and this is a positive step. This will ensure that health visiting, school nursing, community paediatricians, the CAMHS and the looked-after children service will all be able to contribute and have access to the same record. This will also aid timely and effective information sharing across these services, an area we have found to be problematic during our review.

5.1.16 The CAMHS do not currently monitor outgoing referrals to Family Connect. This is a gap as the service cannot assess the quality of referrals or track outcomes. This can mean that staff are not apprised of current safeguarding information that might affect their work with young people. ***Recommendation 2.10****.*

5.1.17 The SATH departments, including ED and maternity, benefit from a dedicated, resource-rich safeguarding page on the trust's intranet where policies, guidance, templates and learning material can be found. For example, the trust regularly issue, through managers and team leaders, a 'One Minute Brief' that is held on the safeguarding intranet page and which provides readily accessible at-a-glance information to support practice. For example, we reviewed one minute briefs on FGM, CSE and bruising in infants which we found to be short but informative with relevant triggers and signposts for further advice. This demonstrates the trust's commitment to promoting safeguarding among the workforce and ensuring they have access to up-to-date information.

5.1.18 The named nurse at SATH has oversight of all referrals made to Family Connect and provides feedback to staff members where shortfalls are identified. However, there is no mechanism for tracking the progress of those referrals and ensuring that the outcome is noted in the patients' records to inform future attendances. ***Recommendation 1.19****.*

5.1.19 Currently, the quality monitoring that takes place for all children's attendances at the ED at PRH does not work well. There is no senior staff oversight within the department of children's attendances to the ED. The system is reliant upon staff members completing the 'green card' with the object of ensuring community health teams are alerted to concerns. As we have set out above under 'Early Help', the current system does not ensure all children's attendances are monitored, as evidenced by the consistently poor standard of safeguarding information in the paediatric cas-cards. The first line of scrutiny is carried out by two different staff members, the Paediatric Liaison Health Visitor and the named nurse for the up to age five and the 6-18 cohorts respectively and this has an impact on consistency.

5.1.20 This operational function of the named nurse also has an impact on her ability to monitor the quality of both the safeguarding practice within the ED and the work of the paediatric liaison role. This is exacerbated by the fact that, apart from administrative support, the named nurse has no additional resources within the safeguarding team to cover the PRH site and the Royal Shrewsbury Hospital site (RSH – not in scope of this inspection) to assist in the quality monitoring, advice and guidance and policy development functions described in the intercollegiate guidance. ***Recommendation 1.20****.*

5.1.21 The safeguarding team within SSSFT have identified practice concerns in relation to adult mental health practitioners responding to invitations to child protection conferences, writing reports and attending core groups. To improve operational oversight of safeguarding practice, all invitations to conferences and all safeguarding referrals are now being monitored by the safeguarding team. There is also a planned audit to measure the effectiveness of engagement of practitioners in child protection processes and also the completion of children's details during assessment. These are positive developments but it is too early to assess the impact.

5.1.22 The design of the risk assessment template in use in the sexual health service does not promote effective questioning of clients to establish risk. For instance, there is confusion about a question that asks clients whether they have had unwanted or unprotected sex and where either the 'Y' and 'N' response is checked without clarifying which question of the two questions it applies to. This is not helpful to establishing risk of exploitation. Further, the questions based on the 'Fraser Guidelines' that help to establish whether young people can provide consent to contraceptive advice and treatment in their own right are not mandatory fields on the template and are not always completed. This means that practitioners might not understand a young person's competence in this area and this inhibits an objective consideration of risks. ***Recommendation 3.11****.*

5.1.23 The substance misuse service has recently developed video conferencing links with the National Probation Service and Community Rehabilitation Company to assist in conducting assessments prior to release of a prisoner. The substance misuse service's information sharing protocol allows timely identification of a child to the relevant service. As this work develops, an audit of the number of children identified, referred to children's social care and the outcome of the referral would provide oversight and effectiveness of this inter-agency work but its implementation is a positive step.

5.1.24 The substance misuse service do not use alerts within their records system to efficiently inform them which service users have contact with children, practitioners have to have personal knowledge of the record to know where information about children is held. This means that it is difficult to have oversight of these cases, manage child safeguarding supervision or to audit the work. It also increases the chance of children being missed, especially when cases are being covered by colleagues or when new staff are recruited who may not have the caseload knowledge that is held by the current team.

5.2 Governance

5.2.1 The CCG is an active member of the Telford and Wrekin Safeguarding Children Board (TWSCB) and is accountable to the board for ensuring safeguarding practice is maintained across the health services. For example, we saw that the CCG are accountable to the board for the dissemination of an information poster directing staff to be professionally curious. This was part of an action following a discretionary review of public protection arrangements commissioned by the TWSCB following the murder of a teenager. The effectiveness of the way the messages from the review are communicated to health staff is to be measured by the TWSCB in an audit scheduled for later in 2016. This demonstrates the culture of accountability engendered by the board which is supported by the CCG.

5.2.2 The CCG and each of the three trusts are represented at strategic level on the TWSCB. Health staff also play a key role in leading the work of the TWSCB. For example, until recently, the TWSCB's quarterly Quality Performance and Operations (QPO) sub-group was chaired by the executive nurse for Telford and Wrekin CCG. The chair role will remain with health as it has recently been transferred to the safeguarding lead professional for SSSFT.

5.2.3 We have reviewed minutes of the meetings of the QPO group for the last year. The group oversee and monitor a number of key areas of audit and improvement activity with the TWSCB. For example, partner agencies participate in peer challenge events based on two key questions from their annual audits carried out under section 11 (Children Act 2004). We note that the audits from SATH and SCHT were part of the challenge event carried out at the end of 2015 (along with the local authority) where the CCG were part of the review team. SSSFT and the CCG itself are to be challenged during the events for 2016. This process is robust and demonstrates a commitment by the health organisations in Telford and Wrekin to assure the candour of the section 11 self-audit process and willingness, thereby, to improve safeguarding practice.

5.2.4 Another TWSCB quality improvement initiative that we have been encouraged by that involves active participation from health agencies is the Multi-Agency Case File Audit (MACFA). This is a series of thematic case reviews, three of which are carried out each year by key personnel and independently chaired and authored. Themes have included neglect, children harming children and CSE. We noted active participation, for example, by the CAMHS in the CSE MACFA at the end of 2015. This MACFA illustrated that involvement by the service is crucial to ensuring planning and direct work with children is co-ordinated where CSE is suspected. The CSE audit also identified issues in the relationship between the sexual health service and CATE team where young people subject of CATE intervention were said to have difficulty in accessing the service and were not prioritised. During our visit to the sexual health service we saw that this had had an impact on service delivery and we have outlined the current relationship as a strength under 'Child Protection' above.

5.2.5 There are clear and accountable governance arrangements in the looked-after children service. Strategic direction is provided by the 'Health of Children in Care' Group chaired by the executive lead for commissioning for the CCG with representation by the designated doctor and designated nurse. Both the chair of this group and the designated doctor represent the CCG and the service on, and are accountable to the Telford and Wrekin Council's Corporate Parenting Board Strategic Group. This group have had oversight, for example, of the developments in the realignment of the designated nurse and named nurse roles that were reported to the group through the designated doctor. However, as we have noted above in 'Leadership and Management', there has been a delay in completing this work leading to the current lack of capacity for effective quality monitoring.

5.2.6 In the CCG's most recent section 11 audit carried out in May 2016, it was identified that not all commissioning and contractual arrangements included section 11 monitoring responsibilities. As a result, the CCG have produced a new set of safeguarding standards setting out expected performance for safeguarding and the monitoring arrangements for all providers who are on NHS contracts or subject to contractual arrangements. This also illustrates the effectiveness of safeguarding performance monitoring within the CCG.

5.2.7 The CCG monitors the performance of the providers in a number of ways. For example, each trust is required to produce a quarterly report of their safeguarding dashboard and these are discussed at quarterly Clinical Quality Review Meetings (CQRM), although these meetings relate to the quality of clinical performance for a range of attributes and not simply safeguarding.

5.2.8 Of note, is the agreement with the CCG that the measurement of the timeliness of initial health assessments should be taken from the point at which the notification is received as opposed to the point at which the child came into care. We acknowledge that this decision was taken to counteract the delays in receiving notifications from the local authority but it nonetheless gives a misleading picture of compliance with statutory timescales. The designated doctor has reported the issue of delays in receiving notifications and we see this is being addressed with the local authority through the Corporate Parenting Strategic Group. ***Recommendation 7.2****.*

5.2.9 All three provider trusts have accountable governance arrangements in place to oversee safeguarding performance. The SATH manage safeguarding activity through a quarterly 'Operational Safeguarding Group' that is accountable to the trust board through the trust's Clinical Governance Executive Committee and the Quality and Safety Group. We have commented under 'Leadership and Management' above about the capacity of the named safeguarding nurse to carry out a strategic or quality monitoring role as well as an operational role. Similarly, the SCHT hold bi-monthly 'Safeguarding Group' meetings that monitor performance and report to the trust board.

5.2.10 The SSSFT has a large footprint which covers areas outside of Telford and Wrekin with the trust being responsible for a range of different services in different CCG areas. Safeguarding accountability is extensive with internal reporting processes through the executive lead for safeguarding and the Quality Governance Committee to the trust board. Policy direction and visible leadership is provided by the trust's safeguarding lead who has overall responsibility for representing the trust at each of the local safeguarding children boards in the trust footprint. The safeguarding lead is an active member of the TWSCB and has recently taken over the chair role for the previously mentioned QPO. The safeguarding lead is supported by a named nurse and a multi-disciplinary safeguarding team. Our review of the trust's annual safeguarding report shows that it is reflective of the current level of practice in the services provided by the trust. These include the provision of training for CSE in the sexual health service and the procedural improvements made to the notification process for child protection conferences in adult mental health, both of which we have commented upon earlier in this report.

5.2.11 Co-production and engagement with children and young people in relation to the service design is under developed within the school nursing service. The friends and family test currently used is acknowledged not to be very young person-friendly. We have been advised that the school nursing service will be considering how to engage children to access and review the service using technology although this has not yet begun.

5.2.12 Due to capacity in the team co-production with looked-after children has been limited in Telford. The looked-after children's team recognise the need to review ways to engage children in the design of the service in Telford and are working with the Patient Advice and Liaison Service (PALS) to develop a child and young person user-friendly way of gaining feedback. This is not yet fully developed but is intended to be in place by December 2016.

5.2.13 The project to re-commission the CAMHS service as an holistic emotional health and well-being service for children and young people under a new service specification, including a service aimed at looked after children, has yet to conclude. However, we are encouraged to learn that design of the new service specification has seen the CCG work with the local authority to engage with service users. This has included consultation with children's health champions, a group of young people specifically recruited by the CCG to contribute their views on a range of services. We see this as a positive commitment from the CCG to ensuring children in Telford and Wrekin have a voice in health service commissioning. Further consultation on the new emotional health and well-being service has taken place with looked-after children, foster carers, teachers and mental health services users. Providers have also had an input into this process through consultation with, for example, GPs and school nurses. We have been assured that the feedback from this consultation has influenced the design of the service so that it better meets the needs of children and young people using the service although we cannot assess the impact of this at this time, and until the new service begins.

5.2.14 Our review of operational practices has highlighted some areas which require improvement as we have evidenced in this report and in our recommendations. However, we have found that there are robust safeguarding governance arrangements in place across the health providers, an overall commitment to safeguarding and a strong willingness to improve. The extensive audit arrangements and the accountability framework provides the platform to drive improvements in practice and this augurs well for forthcoming activity that will arise from this report.

5.3 Training and supervision

5.3.1 We were told that 76% of midwives are trained to standards described at level three of the intercollegiate guidance on safeguarding training. However, they have only completed six hours of this rather than the required 12 to 16 hours outlined for such specialist roles. This is insufficient and may impact on the effectiveness of midwives' safeguarding practice. ***Recommendation 1.21***.

5.3.2 The provision of safeguarding supervision to midwives requires strengthening as the offer and uptake of this is variable. This limits the opportunities to critically analyse the impact of midwives' safeguarding practice and enable further learning and development. However, positively, there are plans to improve the provision as 10 midwives with an interest in safeguarding are to be trained in safeguarding supervision by the NSPCC in October 2016. This will help support the named midwife to deliver safeguarding supervision to staff; although, given the challenges to community midwife resources we have reported earlier, further work may be required to embed this. ***Recommendation 1.22***.

5.3.3 Throughout the course of our visit, we noted plentiful evidence that learning from recent serious case reviews (SCR) and the discretionary review of public protection arrangements had been disseminated to teams and actively promoted throughout the health economy. For example, in respect of the SCR for 'Child B', posters about bruising were clearly displayed around the health visitor's clinic area with health visitors showing a good understanding of the learning from the SCR; information was available on the SCHT and SATH intranet safeguarding pages; training had been provided to front-line staff and 'One Minute Briefs' in bruising in infants were widely available to refer to. We could not assess the effect of this through case sampling as we did not review any cases where this had been identified. However, in a position statement to the TWSCB the CCG have reported that there has been an increase in infant referrals to the hospital to identify if non-accidental injury or neglect has featured and this illustrates the impact of the learning from this SCR has affected local practice.

5.3.4 All health visitors and school nurses attend level three training. The training strategy requires a three-yearly full-day update and enables practitioners to attend multi-agency events provided by the TWSCB. Compliance is closely monitored by the trust's safeguarding team. However, there was some disparity between the figures reported by the trust's staff database and the working knowledge of team managers as to the current status of their team members due to the unreliability of the trust database to gather information about external events. ***Recommendation 2.22***. We have brought this issue to the attention of the Telford and Wrekin public health team, the commissioners of the universal services.

5.3.5 School nurses have attended training on a range of topics including neglect, sexual abuse, child on child abuse and CSE. School nurses have also received some historical training to support them in the management of young people's emotional health (known as the Solihull approach). Knowledge and understanding of FGM is well-developed among school nurses who have benefitted from the insight of the school nurse manager who previously had a national policy development role in this area.

5.3.6 All health visitors and school nurses benefit from one-to-one safeguarding supervision on a three-monthly basis provided by supervisors who have received training in safeguarding supervision and compliance is monitored. A supervision form is completed for each case discussed which examines strengths and risks and which results in an action plan. A copy of this form is kept in the child's records, which means it helps to inform practice.

5.3.7 Supervision in health visiting and school nursing is further enhanced by the recent introduction of a safeguarding records audit as a form of quality assurance. During supervision one record will be audited (in accordance with NMC guidance) as well as a review of safeguarding practice, such as attendance at conference and core group meetings, and an evaluation of health needs assessment and any supervision records. The plan is for managers to identify themes so training can be tailored to meet the team's needs. This is a positive approach and will enable health visiting and school nurse managers to develop operational safeguarding practice.

5.3.8 Organisational support for supervisors in SCHT is improving with the formation of a peer network group of safeguarding supervisors and link workers across the provider's services, set up by the trust's named nurse. During these meetings specific case examples that have emerged during supervision are discussed to enable the supervisors to benefit from case learning. This is a strong initiative and can eventually lead to a general uplift in practice brought about by supervisors with enhanced and supported understanding of safeguarding processes.

5.3.9 Supervision documentation in health visiting, however, is not reflective of the existing risks to the child. The records we looked at simply listed perceived problems for the parents and did not demonstrate a critical appraisal of risks that maintained a focus on the child's needs. This means that risks to children will not be fully understood and may not be properly addressed. ***Recommendation 2.24***.

5.3.10 Staff working in the ED attend level three training and compliance is monitored by the trust's named nurse. Training provided for medical and nursing staff is comprehensive with a range of opportunities to receive training in-house or through the TWSCB. However, it is doubtful whether training in the basic procedures is effective given the shortfalls in record keeping that we have reported on above.

5.3.11 As with the universal services, the managers of the CAMHS report that the trust's staff database is unreliable in gathering information about attendance at external training courses. Training compliance is monitored locally through a spreadsheet and this reflects the strong offer of training at level three. The CAMHS staff can choose which training options they can attend from the menu of TWSCB events or other external courses such as training on neglect, CSE, domestic abuse and parental substance misuse.

5.3.12 The CAMHS have a dedicated CSE and safeguarding link worker who attends all the CATE panels and has developed a good intelligence base as a result. An additional role of this practitioner is to develop supervision in the CAMHS, supported by the trust's named nurse and the previously mentioned supervisors peer network group. Whilst this practitioner has received additional training in safeguarding supervision and has facilitated a group supervision session with CAMHS staff, the process for ensuring all staff receive one-to-one supervision is not yet established. This means that CAMHS staff do not currently have opportunities for professional challenge, support and direction for their cases where safeguarding concerns are identified. ***Recommendation 2.23***.

5.3.13 Practitioners in the sexual health service do not hold cases and so they have access to safeguarding supervision on a case-by-case basis, as and when it is required. In all cases we looked at where contact had been made with Family Connect, safeguarding personnel from SSSFT had been contacted and their advice and direction was reflected in the records. This is good practice as it supports accountable decision making. However, the arrangements for regular safeguarding supervision should be strengthened by making scheduled group sessions available to staff. Sexual health staff are key, front line practitioners and the opportunities for peer support, learning and challenge that effective group safeguarding supervision brings will ensure that good practice is embedded. ***Recommendation 3.12***.

5.3.14 The recent recommissioning of the sexual health service from another provider has identified a level three training gap. For example, the staff have not received any FGM training which inhibits the identification of young people using the service who might have experienced this. This has been remedied with some scheduled level three training within the month following our inspection.

5.3.15 The sexual health staff have recently received CSE training. However, we have reported above under 'child protection' one case where practice has fallen short in the identification of risk and we have seen that a CSE screening tool is not routinely used. This indicates that the service cannot be assured that the training has had an impact on practice. ***Recommendation 3.6***.

5.3.16 'Inclusion' staff working within the substance misuse service have not received level three safeguarding training in accordance with the requirements of their role and rely instead on an annual online component. This could lead to staff having limited awareness of the risks to children and young people related to adults with risk taking behaviour. Of note, is the absence of any children's safeguarding referrals made since September 2015. ***Recommendation 3.13***.

5.3.17 The knowledge and understanding of safeguarding risks by staff in the adult substance misuse service is further inhibited by the absence of scheduled safeguarding supervision. When advice is sought it is not routinely recorded on the client records. Oversight of caseloads is also hindered by the lack of alerts used on the records system to identify when a client has contact with children. This illustrates that the safeguarding focus on a child who has contact with a client is underdeveloped. ***Recommendation 3.14***. We have brought this issue to the attention of the Telford and Wrekin public health team, the commissioners of the substance misuse service.

5.3.18 Adult mental health practitioners have access to a range of different learning opportunities in order to fulfil their learning requirement at level three. A safeguarding 'bulletin board' informs practitioners of a range of e-learning, tools, training and multi-agency events which staff can access as part of their professional development. Attendance is monitored by the trust's safeguarding team and so they can be assured of the current status of all their staff.

5.3.19 The approach to safeguarding supervision in the adult mental health service is strong and versatile. A safeguarding link practitioner and a team leader within the community mental health team have undertaken safeguarding supervision training. Case-holding practitioners are seen on a one-to-one basis for management supervision, within which is a set agenda for safeguarding where the requirement is that at least one case is discussed. A supervision template helps the staff member and the supervisor consider risks and formulate an action plan and this is then entered onto the patient records. The teams also benefit from six-monthly group supervision with the named nurse, with a focus on sharing learning from serious case reviews. Advice and guidance is also available by telephone by the named nurse and actions arising from this are monitored by the named nurse through review of the patient records.

5.3.20 As part of the CCG's three year safeguarding training strategy, training for GPs is being prioritised. GPs are given protected learning time to attend child safeguarding training. The CCG facilitate the use of the out-of-hours provider to cover the GP practices so staff can attend together at least three times each year. The CCG has also invested in an online training system that staff at all GPs can access for basic level training and in the practices we visited, staff spoke positively of the system. Learning in GPs is further enhanced by the quality monitoring visits carried out to each practice by the CCG as reported above under 'Leadership and management'.

5.3.21 There is no formal case specific supervision in place for the looked-after children nurse at present although once the newly appointed designated nurse is in place safeguarding supervision sessions will be held. Weekly informal case discussion with the designated doctor takes place but we saw no evidence of this being recorded in patient records or of these discussions informing practice.

Recommendations

1. Shrewsbury and Telford Hospital NHS Trust should:

1.1 Implement a process in the hospital maternity units to ensure that a routine enquiry about the risks of domestic abuse is made more than once during pregnancy to ensure any evolving risk is identified.

1.2 Utilise an assessment tool for women identified as being at risk of domestic abuse during pregnancy to ensure risks to the woman and her unborn child are understood.

1.3 Refine the questions asked at pregnancy booking so that any paternal or partner's mental ill health or substance misuse is identified and the impact is understood.

1.4 Implement a system that enables oversight of every child's attendance at ED at the Princess Royal Hospital so that information about all attendances is passed to universal services.

1.5 Ensure that ED staff follow the prompts on the patients' paper records designed to elicit information about potential domestic abuse.

1.6 Ensure that the maternity safeguarding link practitioners have sufficient capacity to enable them to provide effective advice and guidance to their colleagues to improve the consistency of practitioners accurately reporting all identified concerns to the named midwife.

1.7 Strengthen the role of the named midwife to ensure she has sufficient capacity to provide effective management oversight of all identified cases of concern within the maternity department and that the priorities and duties of the named midwife post are unencumbered by the requirement to carry out a dual role.

1.8 Ensure that community midwives have the capacity to effectively undertake safeguarding work in relation to women in their caseloads.

1.9 Ensure there are opportunities for joint planning and ongoing work between the maternity service and the adult substance misuse service for women with additional needs due to substance misuse.

1.10 Ensure that discharge summaries fully and accurately reflect the needs of newborn children with additional needs such as those who are looked-after or children subject of a child in need or child protection plan.

1.11 Ensure that sufficient numbers of qualified children's nurses are on duty in the ED at Princess Royal Hospital at all times.

1.12 Ensure the facilities and environment in the ED meets the requirements of the RCPCH standards for children and young people in emergency settings.

1.13 Strengthen record keeping practice in the maternity service so that the impact of any safeguarding concerns is fully described in a vulnerable woman's record and in any referrals made to Family Connect.

1.14 Ensure all safeguarding entries in a woman's record in the maternity service are made contemporaneously.

1.15 Implement a system in the maternity department that enables the timely, effective and corporate receipt and storage of correspondence emanating from child protection processes. This is so that opportunities to attend meetings and to prepare information in advance are not lost and that conference minutes and plans are consistently stored in the same place.

1.16 Ensure that all instances of delayed discharge of well women and babies for non-medical reasons when legal proceedings are being considered are properly challenged with the local authority and escalated as significant incidents with the trust board.

1.17 Ensure that staff in the ED at Princess Royal Hospital record sufficient details on the child's ED record as prompted by the demographic sections and the safeguarding checklists to enable a better understanding of any safeguarding risks.

1.18 Revise the adult paper records in use in the ED to ensure staff are overtly prompted to enquire about children who may be accessible to adults who present with risky behaviour so staff can consider this as part of their risk assessment.

1.19 Implement a system that enables the safeguarding team at SATH to track the progress of referrals made to Family Connect by the ED at Princess Royal Hospital and to note the outcomes in the patient records.

1.20 Strengthen the resources of the safeguarding team at SATH to ensure that the named nurse has sufficient capacity to fully carry out the quality monitoring, advice and guidance and policy development role. This should incorporate a review of the resourcing arrangements for sharing information on the attendance in ED of children and young people with the primary care and universal care services teams.

1.21 Ensure that midwives have opportunities to attend the requisite amount of training stipulated for level three specialist roles in the intercollegiate guidance.

1.22 Ensure the plans to resource the new safeguarding supervision model into the maternity service are implemented.

2. Shropshire Community Health NHS Trust should:

2.1 Implement a process in the health visiting service to ensure that a routine enquiry about the risks of domestic abuse is made at first contact with a pregnant woman or new mother and that this enquiry is repeated at intervals during the child's early years to ensure any evolving risk is identified.

2.2 Ensure health visitors are aware of the importance of assessing fathers or partners in their work with families and refine the assessment and planning tools to support health visitors in asking these questions.

2.3 Strengthen the liaison arrangements between school nurses and GPs to ensure that information about children's needs arising from their work is routinely shared.

2.4 Introduce the planned work to assist school nurses with supporting children and young people with anxieties or emotional wellbeing.

2.5 Provide additional dedicated coverage in the Family Connect team so that the functions of Family Connect are fully supported by an active health presence for each working day.

2.6 Ensure that all outcomes from referrals, strategy meetings or any medium into which concerns have been escalated are noted in the health visiting and school nursing records.

2.7 Revise the system for providing written information to child protection conferences by the health visiting and school nursing services so that parents have the opportunity to review information before it is presented and so that reports effectively articulate risks.

2.8 Revise the system for the timely receipt, recording and storage of written outcomes from child protection conferences so that plans and minutes are placed onto the health visiting record to inform future practice.

2.9 Strengthen the record keeping practice in the CAMHS to ensure that safeguarding information on the patient record consistently sets out the risks.

2.10 Develop processes for managerial oversight of referrals made to Family Connect by the CAMHS and of the outcomes of those referrals so that staff are supported to manage risks with young clients.

2.11 Ensure that CAMHS staff make timely referrals to the CATE processes.

2.12 Ensure that CAMHS staff supply written information for child protection review conferences whether they attend in person or not.

2.13 Ensure that parental health histories are fully documented in initial and review health assessments for looked-after children and considered as part of the assessment.

2.14 Develop the practice for capturing and recording the voice of the child in initial health assessments for looked-after children including whether the child is given an opportunity to be seen alone and to provide their own consent where appropriate.

2.15 Improve the standard of health action plans derived from looked-after children health assessments by ensuring that the plans reflect the assessment and that actions are time-bound with an identified person responsible for carrying out the action.

2.16 Ensure that children leaving care are provided with their health histories in a format that they can use in a meaningful way.

2.17 Ensure that Strengths and Difficulties Questionnaires used in review health assessments are completed by looked-after children where possible.

2.18 Strengthen the arrangements for ensuring that looked-after children with emotional or mental health needs are prioritised by the CAMHS.

2.19 Ensure that information from the CAMHS about the mental health needs of looked-after children is shared directly, and in a timely way with the looked-after children health team.

2.20 Strengthen the capacity of the school nursing team to effectively undertake both safeguarding work and their core universal service function.

2.21 Strengthen the capacity of the universal services administrative support in order to effectively manage the large amount of domestic abuse notifications received from the police service.

2.22 Ensure the staff database used in universal services and the CAMHS enables staff to be credited with attendance at external safeguarding training events so that managers can be assured of their competence.

2.23 Ensure that plans to introduce regular, scheduled one-to-one safeguarding supervision for CAMHS staff are implemented.

2.24 Strengthen the record keeping approach for safeguarding supervision in the health visiting service to ensure the records properly reflect the risks to the child and are, therefore, understood and addressed.

3. South Staffordshire and Shropshire Healthcare NHS Foundation Trust should:

3.1 Where children and families are identified during work with adult clients in the mental health service, ensure that all relevant information, including new information, is proactively shared with other professionals to assist health disciplines in assessing and supporting families.

3.2 Ensure that the families of clients of the adult mental health service feature fully in their risk assessment and that the assessment documentation is aligned to support this.

3.3 Ensure the electronic patient records system in use in the adult mental health service carries an alert for all safeguarding concerns, not just child protection, so that staff can fully understand the levels of need in a client's family.

3.4 Implement a system that ensures the outcomes of referrals made to Family Connect by the sexual health service are communicated to the practitioner and held on the client record.

3.5 Ensure that risk assessments in the sexual health service are repeated for young people who return to the service after concerns have previously been identified in order to consider evolving risks.

3.6 Ensure that the impact of recent training in identifying and responding to risks of CSE in young clients of the sexual health service is monitored. .

3.7 Ensure sexual health service practitioners are supported to attend and contribute to CATE meetings for young people who are their clients.

3.8 Provide training to sexual health staff in FGM.

3.9 Develop the practices in the adult mental health service so that practitioners are actively engaged in and contribute to child protection procedures and that records relating to these procedures are properly stored in the client records.

3.10 Work with the local authority recovery staff to implement a monitoring system in the adult substance misuse service to ensure the safe use of medication storage boxes at the homes of clients who have access to children.

3.11 Refine the risk assessment templates on the records system used by the sexual health service to ensure they prompt practitioners to ask clear questions about a young person's sexual activity and to establish their capacity to consent.

3.12 Introduce scheduled group safeguarding supervision sessions for the sexual health service to enhance peer support, learning and challenge.

3.13 Ensure that health staff working the substance misuse service undertake level three safeguarding training.

3.14 Develop an effective safeguarding supervision model for use in the adult substance misuse service.

4. South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Shrewsbury and Telford Hospital NHS Trust should:

4.1 Work together to ensure that the proposed plans for a dedicated peri-natal mental health service are implemented.

5. Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust should:

5.1 Work together to ensure that the mental health assessment of young people aged 16 and 17 who attend the ED at Princess Royal Hospital is carried out by, or overseen by, specialists in adolescent mental health.

6. NHS Telford and Wrekin CCG should:

6.1 Develop and standardise safeguarding processes in GP practices to ensure that vulnerable children are flagged on the electronic patient records systems and that all documentation emanating from child protection processes is uploaded to the patient record.

6.2 Expedite the deployment of the recently appointed designated nurse for looked-after children.

7. NHS Telford and Wrekin CCG and Shropshire Community Health NHS Trust should:

7.1 Develop and standardise processes to ensure that GPs are routinely asked for and contribute information to the health assessments of looked-after children.

7.2 Ensure that the measurement of the timeliness of initial health assessments of looked-after children is taken from the point at which the child comes into care and not the point at which the notification is received.

8. South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Shropshire Community Health NHS Trust should:

8.1 Work together to ensure that young people who are likely to transition into adult mental health services have their needs properly assessed before reaching their 18th birthday so that transition to and treatment by the adult service is not delayed.

Next steps

An action plan addressing the recommendations above is required from NHS Telford and Wrekin CCG 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.