

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

Children Looked After and Safeguarding The role of health services in Wolverhampton

Date of review:	11 th July – 15 th July 2016
Date of publication:	14 th February 2017
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CCGs included:	Wolverhampton Clinical Commissioning Group
NHS England area:	Midlands and East Region
CQC region:	Central
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Summary of the review

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

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

About the review

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

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

How we carried out the review

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

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

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

In total, we took into account the experiences of 112 children and young people.

Context of the review

The population of Wolverhampton taken at the last census in 2011 was 262,389. The majority (93.3%) of residents are registered with a GP practice that is a member of NHS Wolverhampton Clinical Commissioning Group (CCG). Children and young people under the age of 20 years make up 25.2% of the population of Wolverhampton with 49.6% of school age children being from an ethnic minority group.

The 2016 Child and Maternal Health Observatory (ChiMat) profile provides a snapshot of child health in Wolverhampton. On the whole, the health and wellbeing of children in Wolverhampton is generally worse than the England average. However, in 2015, performance on children in care immunisations was 91.1% vs an England average of 87.8%.

Children achieving a good level of development at the end of reception year in 2015, was 60.9% vs the England average of 66.3%. 16-18 year olds not in education, employment or training (NEET) was good at 4.1% vs the England average of 4.7%.

A significant number of Wolverhampton children (under 16 years) are identified as living in poverty (29.7%) vs the England average of 18.6%. Family homelessness is high at 2.4 per 1,000 vs an England average of 1.8 per 1,000 and in 2015, 135 Wolverhampton children per 10,000 population were looked after by the local authority more than double the England average of 60 per 10,000.

Obesity in children is a challenge to local partners; 12.3% of 4-5 year olds are obese with the England average standing at 9.1% and for children aged 10-11 years, 25.9% are obese compared to an England average of 19.1%.

Children with one or more decayed, missing or filled teeth are 28.2% against an England average of 27.9% and for 2012/13 – 2014/15, hospital admissions for dental caries (1-4 years) were high at 489.9 per 100,000 vs an England average of 322.0 per 100,000.

In 2013, the rate of under 18 conceptions was high at 31.5 per 1,000 compared to the England average of 24.3 per 1,000 and in 2014/15 the rate of teenage mothers stood at 2.5% with an England average of 0.9%.

Emergency department (ED) attendances (0-4 years) were high at 669.3 per 1,000 compared to an England average of 540.5 per 1,000. Hospital admissions for asthma (under 19 years) were high at 405.6 per 100,000 compared to 216.1 per 100,000 England average. Hospital admissions for mental health conditions were slightly above the average of 87.4 per 100,000 at 90.2 per 100,000. Hospital admissions as a result of self-harm (10-24 years) were high at 520.0 per 100,000 compared to the England average of 398.8 per 100,000.

The Wolverhampton Health Related Behaviour Survey shows that 25% of primary school pupils and 48% of secondary school pupils said that they have had an alcoholic drink, 5% of primary school pupils said they had been offered drugs, 12% of secondary school pupils revealed that they have been offered cannabis while 6% had taken an illegal drug; 3% of them in the month before the survey.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Wolverhampton.

The DfE reported that Wolverhampton had 620 looked after children that had been continuously looked after for at least 12 months as at 31 March 2015 (excluding those children in respite care). The table below shows the percentage of these children with completed health care and health assessments. The percentage of children whose immunisations were up to date was 91.1% compared to England average of 87.8%. The percentage of looked after children who had their teeth checked by a dentist was 85.5% comparable with 85.8% which was the England average and 79.8% of looked-after children had their annual review health assessment compared to 89.7% England average.

Commissioning and planning of most health services for children are carried out by Wolverhampton CCG. Commissioning arrangements for looked-after children's health are the responsibility of Wolverhampton CCG, designated roles and operational looked-after children's nurse/s, are provided by Wolverhampton CCG (Designated) and Royal Wolverhampton Hospitals NHS Trust (operational).

Acute hospital services are provided by Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital.

Health visitor services are commissioned by City of Wolverhampton Council Public Health and Wellbeing Service and provided by Royal Wolverhampton NHS Trust.

School nurse services are commissioned by City of Wolverhampton Council Public Health and Wellbeing Service and provided by Royal Wolverhampton NHS Trust.

Contraception and sexual health services (CASH) are commissioned by City of Wolverhampton Council Public Health and Wellbeing Service and provided by Royal Wolverhampton NHS Trust, GP's and Community Pharmacies.

Child substance misuse services are commissioned by City of Wolverhampton Council Public Health and Wellbeing Service and provided by Recovery Near You.

Adult substance misuse services are commissioned by City of Wolverhampton Council Public Health and Wellbeing Service and provided by Recovery Near You.

Child and Adolescent Mental Health Services (CAMHS) are provided by Black Country Partnership Foundation Trust.

Specialist facilities are provided by Black Country Partnership Foundation Trust.

Adult mental health services are provided by Black Country Partnership Foundation Trust.

*The last inspection of health services for Wolverhampton's children took place in June 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services (SLAC). In that inspection, the provision of support to ensure the health and wellbeing of young people in care was found to be **good** and the contribution of health to keeping children and young people safe was found to be **adequate** with some good features.*

Recommendations from that inspection are encompassed within the lines of enquiry for this review.

The report

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

What people told us

Three young people supported by Recovery Near You, the substance misuse service, told us;

“Before being taken into foster care I saw my mum and dad taking drugs, I’ve been working with Recovery Near You for a long time, we do nice activities such as colouring and the place is nice. There’s nothing I would change it helped because I could talk about my family”.

“Recovery Near You is really helpful, I had one worker she was brilliant. If I wanted to use drugs I could ring her up and talk to her about it, I could be honest and it helped me to stop using drugs. I feel very lucky she was a brilliant worker”.

“The Recovery Near You worker would always listen, I like to talk rather than do activity so it’s good I can do that. I think the service is excellent”.

Young People who are first time parents supported by the family nurse partnership said,

“I had a very bad domestic violence relationship while I was pregnant. This programme, for me, saved my life and my daughter’s. If it wasn’t for their constant support I don’t know where my daughter would be”

“The FNP have helped me a lot to get information. The support helped me to be healthy and do stress exercises. They are on the other end of the phone when I needed her. I’ve never had to wait for anything like two or three days”.

“The FNP have helped me with feeding as my baby was sickly and only 4lbs when born. The programme was a real eye opener and made a positive impact on my parenting skills. The programme has helped me to be a mum. I was fine getting up for feeds and I didn’t struggle because of the preparation. I didn’t know anything but with their help I was prepared, I knew what I had to do as a young mum on my own having gone through abuse. I’ve had all the information I needed to be able to care for my child as they have given me all my knowledge”

“They come and visit me at home which is a big help”

“My doctor wasn’t helpful when my baby had a problem with their skin. They gave her 15 different creams and nothing was working. I had to wait to the dermatologist but it’s controlled now because we have the right creams”

Another told us;

"I've got FNP and they're really supportive. They've been involved since I was 16 weeks pregnant. They give me more knowledge to care for myself and my young baby and have helped me to progress my learning which is really good. The FNP helped me to understand about safe sleeping for my baby"

"There isn't enough for young mum's living independently. I haven't always felt listened to, it depends who it is. When FNP come out to me they are there for the baby and for both parents. It's really good: you can talk about things and get advice."

"I couldn't get an emergency appointment with the GP for my baby who was three months old at the time. The receptionist said they were too busy and to phone 111. I spoke to 111 and they advised me to go to the hospital. They saw my baby within half an hour and checked him over thoroughly. I'd like the GP to have some emergency appointment slots"

A parent of a teenage child being supported by CAMHS said;

"CAMHS have been brilliant, although they can be difficult to get hold of by phone as it's always engaged. Without them being there our family would have been completely fractured. They have a flexible approach to supporting us as parents and our child. I discussed a particular approach when we were at child protection. I heard about non-violent resistance training. The CAMHS staff went to get training in this approach so they could deliver it to us. I would like to say they have been first class. They gave my child support when she needed it and needed a tier 4 bed."

"NHS England said there were two beds, one in London and one in Manchester. The Manchester people said they would group similar types to be admitted but my child did not have the same needs as the others on the unit. My child was placed in a unit that was not appropriate for her needs. We didn't realise it was inappropriate until later. We let her go up thinking there were children with similar needs. My child was really scared at the time and didn't have any visitors other than us. It was quite damaging being on your own in that environment with no visitors. The local CAMHS went and visited my child. I was really touched by this. They are aware of how frightening this was"

"We were very much in the hands of the NHS England commissioner and their decision making about beds. I would like to see more availability of appropriate in-patient beds locally"

A foster parent of a child using CAMHS said;

"I have had to wait for 2 years to get supported from CAMHS, I don't like the comment that they won't support until the child is stable. What does stable even mean? After two years I got support. The support I got was excellent, I attended an 18 week course on attachment but the wait was too long and it affected my child".

"CAMHS are not listening to foster carers. Once we got into CAMHS the service has been wonderful, but the CAMHS referral process needs to be better, there is no early intervention".

Foster carers told us;

"The sexual health service was brilliant; my young person wanted contraception and was worried about being judged. They were absolutely amazing, they made her feel comfortable and spoke to her in a young person friendly way, it was actually a fun afternoon out. I think she will access the service again due to her experience".

"The review health assessments at the GEM centre were detailed and they took into consideration my opinions which other services were not doing".

"The phoenix walk in centre service has now closed and this means we have to drive long distance to access this service elsewhere".

"I have a child who has been in care for 10 years, I found he had no back teeth due to care when with birth parents but this had never been picked up, I don't think the health assessments are good at looking at things like that, he had not been to the dentist and it had not been picked up by anyone".

Young people in care and care leavers said;

"My health assessment was alright, I'd seen the nurse before she was friendly".

"I did not have any real health issues, my nurse was really good but there's not help after 18 years and that's a shame".

"I would like to have had my family health history, as I don't have any access to that, so when they ask me at the doctors I have to explain I don't know any of my history. Children need to have this".

"When you leave care and have no family you have no one to talk to and that's hard. There's no easy to access services to support your emotional health. Other foster children I know say the same thing, there's no help".

The child's journey

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

1. Early help

- 1.1 There were good arrangements for women to book into the maternity services provided by The Royal Wolverhampton NHS Trust. Women could book in their pregnancy through their GP and they could also self-refer. The midwifery service was working positively with the refugee and migrant centre to find ways to engage and help the Polish community access the service as a pattern of late bookings from expectant mothers from this community had been identified.
- 1.2 Midwives were expected by the trust to see pregnant women at home at least once ante-natally at either the booking or birth plan visit in line with best practice; facilitating a holistic assessment and enabling exploration of any risks identified in the home environment that could impact on the unborn. However, while we saw some case examples of this, managers could not provide assurance that midwives consistently fulfilled this expected standard as it was not audited or monitored routinely to check compliance (**Recommendation 1.1**).
- 1.3 Risk assessment in the RWT midwifery service lacked rigor. Midwives were expected to undertake risk assessments at booking and again throughout the woman's episode of care. However, maternity records demonstrated that this was not embedded in frontline practice. Midwives were not consistently recording who accompanied the woman to their ante-natal appointments, or whether they were unaccompanied. Female genital mutilation was enquired about but no risk assessment tool was utilised to help evaluate the level of concern. Sexual exploitation was not being routinely assessed for and no assessment tool was used in the service to assist practitioners in the exclusion of this risk (**Recommendation 1.2**).

- 1.4 The majority of midwives had not received training for undertaking an electronic early help assessment. This could prevent midwives from actively initiating the early help offer to women with additional needs in their care. We were told that midwives handed responsibility for this assessment over to children's centre staff however, it is not appropriate to defer this to another service. As a consequence, there was a risk of delayed access to additional support for women and families that would benefit from the timely completion of an early help assessment by the midwife. Following the inspection, we were advised that midwives would complete a multi-agency referral form (MARF) for women who have additional needs, and that therefore there would not be a delay.
- 1.5 Midwives had good links with health visitors and children's centres as these services were co-located and attendance at monthly liaison meetings in the eight children's centre localities from the three services was good. This was helping to share information across these disciplines about families that may benefit from support. GPs, health visitors and children's centres were informed when women booked with midwifery and children's centres then send out information to the expectant mother on what support services they offer, encouraging early engagement with community-based early years support.
- 1.6 Midwives routinely completed appropriate discharge summaries and sent these to the health visitor to ensure a smooth transfer of the new-born. Health visitors received a verbal handover of safeguarding cases prior to discharge from midwifery which aids the transition into health visiting support. Furthermore, midwifery managers were assured that discharge summaries were completed and sent to health visitors as they sampled random cases monthly.
- 1.7 Families and children under the age of five years in Wolverhampton benefited from good delivery of the Healthy Child programme which was monitored closely. Health visitors aimed to offer and deliver 100% antenatal contacts; however it was acknowledged by the service that this had been difficult to achieve in some areas due to capacity issues. Therefore, only those who had been identified as vulnerable received a targeted antenatal assessment. Health visitors were proactively linking with midwifery clinics in children's centres in order to ensure antenatal contact rates are improved.
- 1.8 Health visitors were able to access support from health visitor support workers which was helpful in releasing capacity to target support at the most need. However, we did see a case where delegation to the health visitor support worker was inappropriate as risks appeared to be elevating. It is important therefore, that delegation is carefully monitored by frontline managers (**Recommendation 3.1**). *This has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the health visitor service.*

- 1.9 All children under the age of five transferred into Wolverhampton routinely received an initial transfer-in assessment visit by health visitors. This is good practice, ensuring an opportunity for early assessment of need and encouraging families' early engagement with support.
- 1.10 Family nurse partnership (FNP) in Wolverhampton is well established. We saw a number of case examples that demonstrated improved outcomes for potentially vulnerable teenage mothers and their babies, through joint working with children's social care, children's centre staff and liaison with the midwifery service and GPs.
- 1.11 Monthly multi-agency 'Early Intervention' meetings led by the children's centre were attended by a range of professionals including the police, midwives, health visitors and family support workers. These were effective forums providing an opportunity to for identifying and responding to any concerns that professionals may have through a multi-agency approach.
- 1.12 School aged children were not benefitting from the three universal staged contacts identified in the Healthy Child programme (2009) to help search and identify health needs early. Health assessment by school nursing was undertaken universally at contact stage one when the child enters education at about five years and with children in year six under the national child measurement programme. The Healthy Child Programme recommends an assessment at year 10, however currently this has not been agreed to be implemented in Wolverhampton by the commissioners. Those children identified as overweight or very overweight were referred to the Five Star Families for support. This is good practice and facilitates the improvement of the public health outcomes for Wolverhampton children who are identified as being at a high risk of obesity.
- 1.13 School aged children in secondary schools had good access to drop-ins provided by school nurses. These drop-ins help to improve access to health and wellbeing advice and were reported to evaluate well with young people. We were advised that that managers maintained oversight of child safeguarding practice at the drop-ins and this was reported on in the school nurse annual report and drop-in audit. We were advised that comprehensive assessments were undertaken with young people at their initial visit to the drop-in. The assessment is then reviewed by the school nurse at subsequent visits to the drop-in by the young person and amended as appropriate. We found that assessments undertaken at these drop-ins were being recorded on continuation sheets rather than supported by a comprehensive assessment template with appropriate prompts and triggers which would support consistent best practice. School nurses had good access to resources to aid their assessment of children and young people against risks such as child sexual exploitation (CSE). A specific CSE tool was utilised when practitioners thought there was a risk of CSE based on their history taking rather than being used universally.

- 1.14 Children and young people under the age of 16 attending the emergency department (ED) at New Cross Hospital were booked in at registration where appropriate basic demographic information was collected. However, the relationship of the accompanying adult to the child was not documented and this was acknowledged by the trust as a gap. Under 16s are seen in the new dedicated children's emergency department. The dedicated waiting area provides an environment likely to appeal to younger children. The waiting area is not; however, in the direct sight of ED paediatric nursing staff, therefore any deterioration in a child's medical condition or any concerns about personal interactions between a child and their parent/carer may not be easily identified. The area has a one-way window through which, we were told, triage nurses monitor the wellbeing of children in the waiting area. However, on the day of our visit blinds were drawn across the window. These were drawn back to allow the inspector to see through the window, although visibility was difficult; the blinds were then re-drawn. It would appear, therefore, that there is not sufficient and routine vigilance of the waiting area to reduce the risk of the deteriorating child being promptly identified (**Recommendation 1.3**).
- 1.15 Young people aged 16-18 years were routinely seen in the adult ED rather than having an element of choice. There was no differentiation between the clinical paperwork used in paediatric and adult ED. Therefore, clinicians may not be immediately and constantly alerted to the fact that they were dealing with a child. The trust acknowledged this area for development and took prompt remedial action to ensure paperwork for under 18s was immediately identifiable to staff in adult ED.
- 1.16 We did not see evidence of appropriate protocols being in place in the ED to govern the examination of pre-mobile infants, particularly in relation to head injury and this was of concern (**Recommendation 1.4**).
- 1.17 The ED assessment documentation proforma did not include a specific safeguarding triage or risk assessment which would be in line with NICE guidance and best practice. Following a recent serious case review (SCR), as an interim measure prior to a redesign of the proforma to address this issue, a safeguarding triage stamp had been introduced to improve safeguarding risk assessment practice in the ED. However, case record evidence demonstrated that the safeguarding questions were not routinely being asked. There was also no routine exploration of whether social care was involved with the child or family (**Recommendation 1.5**).

- 1.18 Vigilance and risk assessment in the adult ED for the potential of hidden harm to children as a result of the risky behaviours of adults such as domestic violence, substance misuse or mental ill health was not robust. Adult ED attendees were not asked if they had parental responsibilities or whether there were children in the household. This was a significant missed opportunity to identify the potential for hidden harm to a child or for a child or young person to be left unsupported while the adult attended ED. If an adult attends ED by reasons of risk taking behaviours such as drugs or alcohol misuse, mental health or domestic violence, it is particularly important that all staff are alert to the potential for hidden harm to a child or young person. In a busy ED department, assessment templates which include prompts and trigger question facilitate consistent best practice. These were not in place in RWT paediatric and adult ED and there was a reliance on clinician's knowledge, skills and level of awareness to assess for and identify additional child vulnerabilities or the hidden child. Case evidence we reviewed demonstrated a lack of professional curiosity by both paediatric and adult ED practitioners (**Recommendation 1.6**).
- 1.19 There was an absence of day-to-day managerial oversight of safeguarding practice to ensure that practitioners were compliant with the expected standard of risk assessment. As a result, practitioners may be missing opportunities to identify potential safeguarding or child protection concerns and the trust cannot be assured that the risks of overlooking potential safeguarding risks to children and young people attending ED are being minimised. While the provision of a full-time paediatric liaison nurse was positive and provided an important safety net, it is important that there is routine monitoring of day to day risk assessment as part of ED clinical practice to ensure it is effective and we found this to be underdeveloped. (**Recommendation 1.7**).
- 1.20 Children and young people who attended the ED following an incident of alcohol or substance misuse were routinely referred to the local drugs and alcohol liaison team (DALT). Consent to refer the young person to the service was not required even though the young person may choose not to engage with the service ultimately. This is best practice; ensuring that vulnerable children and young people with substance issues have timely access to help and support at the earliest opportunity.
- 1.21 RWT school nurses participated well in Early Help Assessments (EHA). In school nursing we saw a good level of liaison with partner agencies and health disciplines to support the needs of children and timely responses by school nurses to health concerns when these were raised by schools. We also saw excellent support by a school nurse to a young person at risk of CSE, accompanying her to CASH appointments, convening professionals meetings to promote a team around the child approach and providing ongoing regular support which the child clearly trusted and valued.

- 1.22 Access to low level, tier two emotional health support in Wolverhampton was known to be limited and was being developed by the city council in a range of partnerships such as with Headstart; building resilience in young people for good mental health at an early stage. CAMHS reported that the gap in lower level support had impacted on their service as they were responding to higher numbers of children referred with increasing complexity or presenting in crisis. A good range of CAMHS services was in place. This included a crisis team supporting children and young people with deteriorating mental health in their home, helping to minimise the requirement for in-patient admission. However, waiting times for initial assessment for specialist CAMHS support were well known to be high, providing a significant challenge to health and social care. Concerns about this situation were high among the parents we spoke to, although they valued the quality of service once intervention commenced. We heard positive feedback from foster carers about young people benefitting from the therapeutic intervention once engaged with CAMHS, although they were concerned about how long young people had to wait. We saw case evidence of creative, child centred work by CAMHS practitioners once service intervention commenced, with good outcomes for children. The voice of the child was strongly evidenced.
- 1.23 Whilst there was some oversight of the CAMHS waiting list, this did not include periodic re-assessment of risk and consequently some children may not be sufficiently supported whilst they wait for their initial assessment. There was a considerable risk that their mental health may deteriorate as a result. Waiting times were closely monitored by the CCG with the service using Future in Mind money to offer an additional 12 initial assessment sessions per week to help reduce the waiting time (**Recommendation 2.1**).
- 1.24 Although initial assessments undertaken in CAMHS include a comprehensive risk assessment, cases we reviewed demonstrated that practitioners did not routinely re-assess on a three monthly basis in line with trust policy and protocol. Although CAMHS practitioners had undertaken training on the use of CSE risk assessment tools, we saw no evidence that practitioners were regularly assessing for risks of CSE (**Recommendation 2.2**).
- 1.25 Transition for young people from CAMHS into adult mental health where thresholds for adult support are met, generally worked well. However, there were not services to support young adults with ADHD or ASD other than the young person's own GP. The learning disability Inspire team did continue to support some young people into early adulthood based on individual need and service capacity but there is a recognised gap in on-going provision. Development of multi-agency services and pathways as a result of the implementation of the Children and Families Act 2014 should help to address this deficit. (**Recommendation 4.1**)

- 1.26 SWITCH is an innovative service from Recovery Near You, aiming to reduce the number of looked after children in Wolverhampton. This provides a one to one befriending service aimed at vulnerable women and their partners to prevent repeat removals of the children from their care. This impactful early help service was being offered to all women and partners across Wolverhampton within this cohort; they did not have to be using substances to qualify.
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2. Children in need

- 2.1 Wolverhampton midwives were able to access and input into women's records in all but two GP surgeries. We saw the value of this in supporting effective risk assessment and information sharing in one case example where the GP records indicated the woman had a history of mental health problems. The woman had not disclosed this to the midwife at booking however, so the midwife was able to add the detail of this to the maternity ante-natal risk assessment in the additional comments section. This ensured that practitioners in the service were aware and additionally vigilant to these issues in their on-going assessments of risk and facilitated effective safeguarding planning to take place to protect the unborn.
- 2.2 There was a midwifery service expectation that pregnant women will be seen alone once as part of their ante-natal care. This enables the women to disclose any sensitive issues or domestic abuse to the midwife. The standard set by the RWT of a single posing of the domestic violence question was a minimal expectation as best practice would be to repeat this at least once more during pregnancy as domestic violence can escalate or emerge during this period. However, case records examined, demonstrated that midwives were not consistently fulfilling the trust's minimal requirement and no operational monitoring was in place to ensure practitioner compliance (**Recommendation 1.1**).
- 2.3 Pregnant women experiencing mental health difficulties were not benefitting from access to an effective specialist multidisciplinary perinatal mental health pathway and Wolverhampton was therefore not compliant with NICE guidance. Midwives were not able to make direct referrals to adult mental health and were reliant on the woman's GP to do this, although if deteriorating mental health was of concern to midwives they could refer the woman to the crisis team who would intervene with support. We were told that pregnant women experiencing low mood wait for 12-14 weeks for assessment by the Healthy Minds team. As a consequence, women were at risk of an escalation of their mental ill health. However should admission for in-patient treatment be required, access to acute mental health beds locally could be challenging with women routinely being transferred out of area to receive the care and treatment they require (**Recommendation 2.3**).

- 2.4 The specialist midwife for vulnerable women had established good links with Recovery Near You, the adult substance misuse service, and there was a fortnightly meeting to share information. However, it was not always clear how this informed work with individual women as we saw no evidence that decisions or jointly agreed actions were routinely recorded in the woman's case record. In one case, a mother was reported to have substance misuse issues but there was no evidence of any joined up approach with the substance misuse team prior to an initial child protection case conference (**Recommendation 1.8**).
- 2.5 RWT have a specialist midwife post for vulnerable women but this was vacant when this review was undertaken. This was a caseload holding post of usually around 20 to 25 women experiencing difficulties with mental health, substance misuse, teenagers not engaged with family nurse partnership (FNP) and asylum seekers. Community midwives could refer women by completing the ante-natal risk assessment or by speaking to the specialist midwife. While the post remained vacant, the specialist safeguarding midwife was overseeing the role in addition to her delegated duties for the operational safeguarding role. This is discussed further in 5.1.5 below.
- 2.6 Ante-natal support to young women who are themselves looked-after children and pregnant was underdeveloped. Case examples seen had incomplete maternity risk assessments, and there was no evidence that practitioners had ascertained the young person's legal status as a looked-after child and who held parental responsibility for them. The midwives were not engaging closely with other professionals around the young person; social worker, looked-after child health practitioners, the specialist midwife or teenage pregnancy health visitor to ensure an effective team around the child approach in order to safeguard both the unborn and the expectant looked after young person (**Recommendation 1.10**).
- 2.7 For some family cohorts with a known likelihood of additional vulnerability, there were three specialist health visitors for travelling and asylum seeking families, teenage pregnancies and homeless families. Each GP in Wolverhampton had a named link health visitor, attached to their practice. There was a service level communication agreement between health visitors and GPs, recommending that health visitors and GPs meet every 6 weeks as a minimum, to discuss safeguarding and vulnerable cases. However, practice was variable and not all GPs held regular liaison meetings. This meant that some vulnerable and complex families in Wolverhampton may not receive a co-ordinated approach to their care. This had been identified by senior health visitor managers as an area for further development. Where GPs were holding liaison meetings, agreed plans of action and outcomes were not always recorded in health visitor records (**Recommendations 5.1 and 3.2**). *This issue has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the health visitor service.*

- 2.8 In health visiting, screening tools were used to assess maternal mood, based on the Whooley NICE guidance questions, as well as including questioning around domestic abuse at each key contact. However, we found that questions relating to maternal mood and domestic abuse were not routinely being asked and recorded (**Recommendation 3.3**). *This has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the health visitor service.*
- 2.9 School nurses had been trained in approaches such as the Solihull approach and “Shut Up and Move On” in proactively supporting the needs of children and young people with low level or emerging emotional and mental health difficulties. We found that school nurse assessments of young people’s mental health however, were often reliant on individual professional expertise to assess the level of risk in for example, children and young people that self-harm. Assessments were not routinely underpinned by the use of any risk assessment tool. Following the inspection, we were advised that school nurses have a mental health tool kit they devised themselves and use with young people. However, we did not see evidence of this being used routinely in our visit to the service which indicates practitioners may be missing opportunities to ensure the assessment is robust. We can see that use of this tool periodically with a young person would be helpful in tracking changes in the mental health of the young person (**Recommendation 3.4**). *This has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the school nurse service.*
- 2.10 Locating a school nurse practitioner in the youth offending service was helping to facilitate a joined up approach to children with additional vulnerabilities and looked-after children known to both the school nurses linked to the pupil referral unit and the youth offending service.

- 2.11 Partnership working between health visitors, the midwifery service and with adult mental health and the substance misuse, Recovery Near You service, could be improved. A lack of effective communication sharing and co-operative working between services is a feature of serious case reviews. Case examples identified this as an area for development and this was acknowledged by service managers. Family Nurse Partnership (FNP) nurses on the other hand, reported good joint working with adult mental health. Adult mental health managers had a clear expectation that practitioners would share recovery action plans, contingency plans or relapse indicators with health visitors and other relevant professionals. This can be highly effective in facilitating the early identification of deteriorating mental health by other health professionals and ensuring the parent's early engagement with specialist support. However, health visitors reported that this does not happen routinely and we saw no case examples. Recovery Near You did not routinely advise health visitors or school nurses when a young person or parent registers with them and this could result in these services not having all key information about what services are working with a family (**Recommendations 2.4 and 6.1**). *This issue has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the Recovery Near You, health visitor and school nurse services.*
- 2.12 There were effective arrangements in place between the local authority and RWT school nurse service to ensure the health of home educated children and young people was monitored and addressed with a dedicated school nurse assigned to oversee this cohort of potentially vulnerable children. The nurse seeks parental consent to school nursing input. However, if this is declined, the nurses will inform the child's GP. This is important as the GP is the primary health record holder.
- 2.13 CAMHS had good links with the paediatric ward through the CAMHS paediatric liaison nurse. The practitioner had supported paediatric staff on the ward in being able to talk to young people that self-harm and provided some training for staff on this topic. Outcomes of CAMHS assessments undertaken on young people who were in-patients on the paediatric ward were not always shared with key professionals and services and we saw one case example where the GP was not notified of the outcome of the CAMHS assessment and plan for the young person's ongoing care.

- 2.14 The 'Think Family' approach was well embedded within the Recovery Near You adult substance misuse service. The assessment documentation and electronic record systems allowed children to be easily identified and safeguarding flagging was consistently used to a high standard. We were impressed by the use of an interactive genogram which supports practitioners to think about other children living in the home, those in care of the local authority and which also has the facility to link other adults using the Recovery Near You service. Practitioners completed an extensive risk assessment form for each case when it was discussed in supervision; this was then recorded in case records. We saw case evidence that these discussions and subsequent risk re-evaluation was clearly informing day to day safeguarding practice.
- 2.15 The Recovery Near You computer system allows for a comprehensive risk assessment which considered children, it was clear that practitioners used this on a regular basis to inform practice and managers have good oversight of practitioner compliance. Case records demonstrated practitioners have a clearly child-focused approach while working with the adult, there was good detail recorded about the child's presentation, demeanour and parental interaction. The impact of parental drug misuse on the child was given strong consideration. Should safeguarding concerns continue or cases be particularly complex, cases were brought to a monthly senior safeguarding meeting for discussion with the team manager and the Recovery Near You social worker and appropriate action taken to protect the children.
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3. Child protection

- 3.1 The quality of referrals to MASH seen in midwifery was variable with no evidence of operational managers' quality assuring these to ensure there was a clear articulation of the risk of harm to the child. Copies of referrals to MASH were not always retained on the case record and this is poor practice; rendering the patient record incomplete and undermining managers' ability to either quality assure practice or effectively support any invocation of the escalation policy if children's social care do not take up the case (**Recommendation 1.11**).
- 3.2 Referrals from health visitors were also of a variable quality and could be strengthened through a sharper focus on analysis. However, we found that FNP referrals articulated risk clearly (**Recommendation 1.11**).

- 3.3 In Recovery Near You, the single multi-agency referral form (MARF) reviewed was of a very high standard, with sufficient detail for social care to really assess the risk to the child. The practitioner clearly articulated the parents' diminished ability to care for the child whilst under the influence of substances and the lack of engagement with the service. This facilitates good decision making in the MASH on what level of intervention is likely to achieve the optimum outcome for the family and for the child.
- 3.4 In BCPT CAMHS and adult mental health, there was no robust quality assurance process within frontline teams to support practitioners in the clear articulation and analysis of risk for reports submitted to case conference and referrals to children's social care and the quality of referrals we reviewed in these services was variable in common with other services (**Recommendation 2.5**).
- 3.5 Practitioners and managers across health services and the named GP reported that they were increasingly receiving notifications from the MASH that referrals have been received and what action is being taken as a result of the referral. This was not yet routine however and in CAMHS we saw case evidence that practitioners in the service were not always proactive in chasing up this up with the MASH. Black Country Partnership Trust named nurses and managers were clear in their expectation that practitioners would ensure that they have received this and entered it into the case record but acknowledged that this did not always happen.
- 3.6 In RWT midwifery, assessments within the service identified risks and children's social care was routinely being informed of these. Social workers subsequently undertake a pre-birth assessment. However, the practice was that this was not shared with the midwife or other key services which may have a close involvement with the mother. This created potential risk that key information may not be known by all the relevant professionals. A child protection checklist was used which included key details to aid the discharge process such as; when to notify the social worker, parental contact with the baby, and discharge destination. This could be reviewed and updated by the core group members should a change be made, for example; in legal status. However, these were not detailed. They did not include information about why the unborn baby was vulnerable and required the checklist or whether the parents had been consulted in the checklist's development. There was an expectation that the content of the child protection plan, the checklist and the information recorded in the ante-natal summary were sufficient to inform midwives providing care of the safeguarding risks and needs of the new mother and baby. When the checklist was in place, this appeared to work in a satisfactory way. However, we found that this was not always present on the maternity record. The absence of this key child protection information and guidance to hospital midwives if the woman presented in labour would potentially raise risks significantly that the new-born would not be safeguarded effectively (**Recommendation 1.12**).

Good Practice Example: *Midwives at Royal Wolverhampton Hospital Trust made persistent efforts to engage a pregnant woman with substance misuse issues with the maternity service. The midwives were effective in discharging their safeguarding duties; submitting reports and attending child protection case conferences.*

The specialist midwife for safeguarding children emailed the woman's details and shared information about the case with the hospital neo-natal unit in advance in case the baby was in need of their intervention.

The outcome was that effective multi-agency working ensured good antenatal support to the mother and protected a vulnerable new-born with the child being placed into foster care soon after birth.

- 3.7 For new-borns, discharge planning meetings involving all key services involved with a baby known to be vulnerable or on a child protection plan, were not being held routinely. We regard this as a gap as circumstances can change immediately or soon after birth and the provision of discharge planning meetings for those known to present risk, helps to ensure that all agencies involved are clear on their role in safeguarding the new-born immediately on discharge. Midwives do routinely complete written child protection reports for case conferences. Case examples seen however, indicated that the information submitted for pre-birth conferencing was not inclusive of the outcomes of risk assessments or the concerns identified by midwives. Managerial oversight of the effectiveness of midwifery child protection practice through routine monitoring of reports and case recording was lacking. Overall, although we saw some good practice, we were not assured that the safeguarding and child protection antenatal and immediate post-natal pathway is sufficiently robust between midwifery and children's social care. We understood that this was about to be subject to review by children's social care and RWT and we regarded this joint review as timely (**Recommendation 1.13**).
- 3.8 We were told that there are sometimes prolonged hospital stays of medically fit mothers and babies as a consequence of social care plans not being completed prior to birth and this is not appropriate. *This has been drawn to the attention of the Director of Children's Service in Wolverhampton City Council.*
- 3.9 Chronologies were routinely and well used by health visitors for all safeguarding and vulnerable families in line with best practice. School nurses were just beginning to introduce the use of chronologies into their casework records, although this was not yet embedded practice.

- 3.10 Multi-agency risk assessment conferences (MARAC) arrangements were well established and continue to work well in Wolverhampton across health services. School nurses did not always receive good information about other incidents of domestic abuse outside of MARAC, although we understand that the RWT safeguarding team do routinely receive police domestic violence notifications. We saw one case in adult mental health where the detrimental effect of domestic abuse and violence on a child was not identified as a safeguarding risk. Although there was also good practice in the case, set out as a case example below, it is important that all health services are sighted on the potential long-term harm to the health and wellbeing of children living with domestic abuse (**Recommendation 4.3**).
- 3.11 In most services, robust “did not attend” (DNA) arrangements were in place. For example, in midwifery, practitioners regularly completed the DNA document and recorded their resultant actions when women failed to attend an appointment. In adult mental health however, the DNA pathway and flowchart only required the practitioner to discuss the case with a supervisor if risks to children had previously been identified rather than to ensure the DNA itself did not present potential safeguarding risk. Operational managers acknowledged that this may not best support Think Family practice (**Recommendation 2.6**).

Case Example: *A male child aged seven engaged with CAMHS for anger management had witnessed domestic abuse and violence between his parents, was being shouted and sworn at by mother. The psychiatric liaison team based at the hospital identified no safeguarding concerns in their assessment although information was documented which evidenced safeguarding issues were clearly indicated. This was of concern as this team frequently undertake initial assessments of this nature and may be missing child safeguarding issues in other cases. This was acknowledged by the operational manager and addressed promptly.*

The health visitor for the family liaised with adult mental health to alert the practitioner to children in the case and requesting them not to discharge the mother from adult mental health if she did not attend an appointment.

The adult mental health practitioner took this on board and made continued and diligent efforts to engage mother with the adult mental health service.

- 3.12 The above is one of several examples seen of adult mental health practitioners making dogged efforts to engage parents who were reluctant to engage with the service and similarly, we saw cases where practitioners made diligent efforts to track down clients who started to DNA mental health appointments when they had children.

- 3.13 The Black Country Partnership Trust electronic records systems had the facility for practitioners to put alerts on case records where there are children subject to CIN or on child protection plans and there was a clear managerial expectation that they should do so. However, only one case reviewed in adult mental health had an alert on the record and there was no evidence of operational managers monitoring practitioner compliance. This was an area for development in both adult mental health and CAMHS (**Recommendation 2.7**).
- 3.14 There was an expectation across all health services that where practitioners were engaged in a case in which a child is subject to a child protection plan then the practitioner will attend case conferences: monitoring of this and of practitioners' submission of reports by operational managers was limited however. In health visiting and family nurse partnership case conference reports were routinely submitted, were detailed and articulated the practitioner's concerns well. The local authority template for reports in use at the time of the review did not prompt practitioners to analyse risks for the child and we found that reports submitted by school nursing, lacked this important detail. We noted that the template was about to be reviewed.
- 3.15 Not all health services' practitioners submitted reports in advance of child protection case conferences as well as attending, which would be best practice. This was not a local requirement at the time of the inspection but arrangements were being reviewed. For example, mental health practitioners were expected to submit a written report only if they were unable to attend. Attendance and submission of reports was not monitored however, and managers in adult mental health acknowledged that in practice, performance may not be as good as they would like. CAMHS practitioners invited to attend initial child protection case conferences were not always feeding back the outcomes of case conferences or accessing quarterly safeguarding supervision for such cases and this was not compliant with BCPT policy. This is addressed further in paragraph 5.3.13 of this report (**Recommendations 2.8 and 2.10**).
- 3.16 We were told that practice was variable in how routinely social workers invite adult mental health practitioners to CIN and child protection meetings. No work had been done with children's social care on developing an effective invitation pathway that minimises the risks that adult service practitioners, working closely with the case, miss key meetings (**Recommendation 2.10**).
- 3.17 There was a clear expectation that Recovery Near You practitioners attend safeguarding meetings and evidence of this was seen in records. Managers did not actively monitor this attendance or have a single point of access for invitations to facilitate this. If practitioners attended a case conference they did not write reports, this was identified as a gap in practice. Management and the local authority were already working together to produce a standardised report form (**Recommendation 6.2**). *This issue has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the Recovery Near You service.*

- 3.18 In child protection and CIN case conferences, professional differences were generally aired and resolved appropriately and we saw examples where use of the escalation policy had been appropriate to invoke managerial scrutiny of a conference decision. There was scope for Recovery Near You to strengthen their use of escalation in appropriate cases.
- 3.19 It was not clear that CAMHS practitioners were sufficiently engaged with the multi-agency child sexual exploitation (CSE) arrangements. We saw case evidence that practitioners were not considering the potential for risks of CSE sufficiently and where other professionals had identified risk of CSE for children with whom CAMHS were involved, CAMHS practitioners were not always well engaged in the multi-agency approach (**Recommendation 2.11**).
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4. Looked after children

- 4.1 Wolverhampton children and young people who become looked-after and subsequently placed out of City were often not having their health needs assessed in a timely way in line with statutory requirements. This was an on-going challenge for children's social care, the CCG and the specialist health service provider RWT. This is addressed in more detail in paragraph 5.1.2 of this report.
- 4.2 Advanced nurse practitioners (ANP) rather than paediatricians had been carrying out initial health assessments (IHAs) for certain cohorts of looked-after children on a regular basis for a number of years and the appropriateness of this happening as routine practice was questionable. The CCG designated looked-after children's nurse acknowledged that this pathway needed to be reviewed to ensure that children and young people coming into care have their health needs assessed by medical practitioners in accordance to statutory guidance, and be subject to robust quality assurance. Audits undertaken locally highlighted the general standard and quality of initial health assessments undertaken by ANP's were high compared with those undertaken by medics, including a distinct voice of the child present throughout. ANPs received no formal one-to-one safeguarding supervision and this was a risk, particularly in light of them undertaking IHAs (**Recommendation 1.14**).
- 4.3 Wolverhampton has a small cohort of unaccompanied asylum seeking children (UASC) and we reviewed two IHAs from this cohort. We were not assured that these were undertaken by an appropriately qualified clinician who had also undertaken specific training on the asylum seeking experience. One assessment had been undertaken without the provision of an appropriate interpreter. This is not acceptable practice and this young person's physical and emotional health and wellbeing needs may not have been properly identified as a result (**Recommendation 1.15**).

- 4.4 Good attention is given to ensuring that appropriate consent is recorded and this was present in all records reviewed. In many instances young people had given their own consent. This is good practice, enabling the young person to engage with the health assessment and begin to take responsibility for their own health.
- 4.5 Overall, records reviewed for both IHAs and RHAs did not meet expected standards. IHAs commonly did not contain parental or family health histories. This is vital information which can only be gathered when the child or young person first enters care, secured within the IHA documentation at the initial health assessment and subsequently follow the child throughout their journey through care. In a number of records the IHAs were missing, losing the opportunity for staff to review any relevant health implications from the birth family. One care leaver told us during the week; “I would like to have had my family health history, as I don’t have any access to that, so when they ask me at the doctors I have to explain I don’t know any of my history. Children need to have this”. This comment is typical of those we hear most frequently when we speak to young adult care leavers who cite lack of parental and birth health history as something that has detrimental effects on their sense of self and can present difficulties for them when entering the job market or accessing health care (**Recommendation 1.16**). *This issue has been drawn to the attention of City of Wolverhampton Council.*
- 4.6 Health plans developed from IHAs and RHAs were not SMART and we could not see evidence that these were being effectively quality assured. There was no clear formal quality assurance pathway or tool being used. Although we did see links made with previous health assessments in some cases, most RHAs we saw were episodic and did not review the health outcomes from the previous RHA or the IHA, so there was inconsistent practice (**Recommendation 1.16**).
- 4.7 It was hard to see who was taking responsibility for ensuring that the identified health needs of individual children were met as there was no single looked-after child health record to facilitate the effective monitoring of the meeting of health needs. Underdeveloped operational practice monitoring in health visitor and school nurse services exacerbates the potential for the health needs of looked-after child to not be met promptly. The looked after paper records did not provide an overview of the whole journey of the child, in most of the records reviewed there was no journal to record any actions taken by the looked after health team. There was no audit trail as to who had been sent copies of health action plans and any documentation about follow up (**Recommendation 1.16**).

- 4.8 The specialist CAMHS looked-after children's service provides good quality support to looked-after children including those placed out of area within a 20 mile radius. This was helping to maintain continuity of care for children who often experience frequent change whilst on their care journey. However, some looked-after young people experience significant waits for CAMHS support and this highly vulnerable cohort were not having their emotional health needs met in a timely way. Where the service was supporting a looked-after child, foster carers had access to a nurture group to help carers understand attachment. The course was reported to evaluate well with foster carers who had attended. The looked-after children's CAMHS service worked well with children's social care, offering consultation, spending a day per week in a children's social care base and providing monthly support to a local authority residential home. Strengths and difficulties questionnaires were not being best utilised to inform assessments and reviews of young people's emotional wellbeing (**Recommendation 2.12**).
- 4.9 We did not see evidence of other agencies being contacted to inform the initial or review health assessment. Even when children were known to CAMHS there was no liaison or correspondence between the service and the looked-after child health professional. GPs are not being asked to provide information for review health assessments and this is a missed opportunity to ensure the assessment of the child's health is fully comprehensive. After a child or young person has had a health assessment, there is no standard as to with whom the health assessment should be shared. This could lead to inconsistencies in practice, duplication and looked after children's health needs going unmet (**Recommendation 1.17**).
- 4.10 The care leavers' health offer was underdeveloped and care leavers were not being well supported by health as they enter adulthood. This aspect of the looked-after child health service was a priority for development by the designated looked-after child nurse (**Recommendation 1.18**).

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 It is commendable that the Wolverhampton CCG has separated the designated nurse roles for safeguarding and for looked-after children into separate posts. With the growing complexity of both these areas of responsibility, this best enables dedicated and focused leadership and governance to be established: increasing the designated capacity to support services and practitioners and drive improvement. The named nurse post had been vacant since March 2016, creating a hiatus which had been filled in part by internal, interim arrangements. The current commissioning arrangements and the recurrence of a backlog of health reviews had led to an interim position where the designated nurse for looked after children undertook clinical activity; carrying out health reviews for looked after children placed in surrounding boroughs. This had a significant impact on the designated nurse's capacity to have effective oversight of the looked-after children's health service however. Releasing the designated nurse's capacity to lead improvement through the recruitment of the new named nurse would be beneficial as a catalyst for change. The designated looked-after children's nurse had a good understanding of the challenges in the service and at the time of the review was developing the strategy and preferred service model to take the looked-after children's health service forward.

- 5.1.2 The new designated looked-after children's nurse role facilitates the development of an effective three way partnership between health commissioners, social care and RWT as the provider and the establishment of a robust performance management framework. However, it is essential that all agencies take ownership and work together to effect real change through a robust and equitably driven whole system approach. The foundations for this are good; the pooled out-of-area placement budget between local authority and the CCG and the established looked-after children's health steering group. There was not an effective looked-after children's health database in place to facilitate effective governance within RWT and it was difficult to see how the RWT internal performance reports on the timeliness of IHAs and RHAs provided effective performance management information. The data reported was aggregated into a single overall percentage of completed IHAs and RHAs. This did not correlate with the separate breakdown and narrative summaries for each activity. The CCG was strengthening its approach to governance of performance and the bimonthly multi-agency looked-after children's health group provided a good forum through which the partnership could develop robust shared performance data.
- 5.1.3 Establishing the performance dashboard and the quarterly evidence-based assurance framework were positive steps by the CCG to strengthen governance as were the regular quality visits to providers led by the designated nurse to monitor safeguarding practice across providers.
- 5.1.4 Health was well engaged with the LSCB and its sub-groups at appropriately senior levels of authority. The chair of the LSCB was increasing the level of multi-agency challenge through increased use of section 11 audits and probing of performance information and data set out in providers' annual reports. This was encouraging as children did not feature sufficiently strongly in last year's trust reports. A multi-agency "lessons learnt" forum was well regarded by partner agencies as providing good opportunity to drive improvement in safeguarding children and young people across the city.

- 5.1.5 The development of a multi-agency safeguarding hub (MASH) in Wolverhampton is a real strength demonstrating positive partnership working and there is good commitment across health providers to participate in the arrangements. Investment by the CCG in the provision of new safeguarding specialist nurse roles from RWT and Black Country Partnership Trust to be located in the MASH was positive. Dedicated posts ensure that no additional capacity pressures are created in the safeguarding teams and facilitate the MASH's prompt access to mental health clinical expertise and health information on individuals, thus facilitating optimum decision making. The agreement between RWT and BCPT that these specialist practitioners will have "buddy" arrangements to ensure a constant health presence and mutual access to each trust's information systems is also a strength; strongly indicative of the multi-agency commitment to the development of a strong MASH model. This arrangement was a credit to both organisations and evidenced good partnership working. We observed the immediate benefit of the new RWT specialist nurse presence in the MASH who was able to access key health information about a child which elevated the risk rating from amber to red. The practitioner presented the information at the subsequent, promptly convened strategy meeting with clarity and authority and appropriate multi-agency safeguarding actions resulted.
- 5.1.6 The post of head of midwifery is a statutory requirement. However, this post had been held on an interim basis for an extended period of time with the post holder also being identified as the named midwife. The specialist safeguarding midwife had taken on significant elements of the named midwife role in addition to her substantive delegated safeguarding role resulting in capacity pressures which were not sustainable. The vulnerable women's midwife post was vacant at the time of the review and was also being overseen by the safeguarding midwife. The matron for midwifery recognised that this arrangement whilst short-term carried some risk and should be placed on the trust risk register. The vacancy for the specialist midwife for vulnerable women is due to be recruited to in the Autumn of 2016.

- 5.1.7 We identified, through strong case evidence, that effective monitoring and oversight arrangements were not in place in RWT's ED and midwifery services. Operational governance of frontline midwifery practice was significantly underdeveloped and of some concern with managers in the service not having an accurate picture of whether midwives were compliant with RWT practice standards. Reporting arrangements into the trust board were in place. The named midwife reported to the chief nurse with operational safeguarding activity being reported quarterly by the specialist midwife for safeguarding in a report to the trust board. However, the named midwife was not part of the trust strategic safeguarding meetings. The intercollegiate document states that the named midwife should be part of the trust safeguarding team yet this was not evident. Managers in midwifery were also unclear about their participation in LSCB sub-groups and it was not clear how the existing named midwife arrangements and leadership structure were influencing the strategic development and improvement of maternity safeguarding practice in RWT (**Recommendation 1.9**).
- 5.1.8 A regular meeting takes place between the head of midwifery, the matron and the specialist midwife to discuss safeguarding performance and themes within the service. We saw minutes of these meetings which were not detailed although they identified the key themes and resultant actions. Themes discussed included safeguarding training, domestic abuse, record keeping and risk assessment. We found deficits in these areas within the service and without effective and robust practice oversight and case monitoring being in place, it is difficult to see the impact of this meeting in driving continuous improvement and in ensuring the most vulnerable are properly protected (**Recommendation 1.9**).
- 5.1.9 There was strong safeguarding leadership from the designated professionals and the named GP. Named nurses in the two provider trusts were knowledgeable and accessible, providing sound advice, guidance, support and feedback to practitioners. The safeguarding team in RWT was operating under significant capacity pressures. At least in part this was contributing to an underdeveloped supervision offer to frontline practitioners and the inability of the safeguarding team to fully lead, drive and oversee safeguarding practice development in services. An example being in the integrated sexual health and adult HIV service where the trust's adult safeguarding advisor for sexual violence had the ability, knowledge and enthusiasm to provide leadership and support practice improvement but lacked the capacity to do this effectively. We understood that a business case to inform a review of the safeguarding team provision at RWT was being prepared by the head of safeguarding and we viewed this as timely (**Recommendation 1.19**).

- 5.1.10 The school nursing service was commissioned to provide universal and targeted services to children from 5 years of age to 19 years of age including some specialist schools. This included children that attend academies and those that are home educated. However, commissioning arrangements for those aged 16 to 19 year olds accessing education in college, some faith and independent schools did not benefit from the offer. As a consequence not all school aged children have equitable access to the school nursing service in Wolverhampton. *This issue has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the school nurse service.*
- 5.1.11 Commissioners had introduced a new service specification requiring the CAMHS crisis team to respond to referrals for children and young people with deteriorating mental health within four hours. This facilitated young people having prompt access to specialist services and potentially reduce the need for ED attendances and hospital admissions for young people with fragile emotional health, although it was too early at the time of the review to evaluate the impact.
- 5.1.12 In the Black Country Partnership Trust adult mental health service, senior managers and the Head of Safeguarding were clear that the trust was developing its systems, processes and practice on the principles of Think Family and that they were working to embed this in practice across the different teams. It remains a work in progress and, although becoming increasingly rare, we were told that some adult practitioners were still finding it challenging to fully understand and consistently discharge their child safeguarding responsibilities as they feel this will inhibit or be detrimental to the therapeutic relationship with their client. We saw and heard some case examples which support managers' assessment that Think Family is not yet fully embedded. The safeguarding team and operational managers we met with were open to learning from external scrutiny to help drive continuous improvement and, positively, some areas for development identified in our visit were addressed immediately.
- 5.1.13 Mental health teams have safeguarding "Link" practitioners identified who take on a range of responsibilities to enable them to act as a conduit for information about safeguarding coming from the trust's safeguarding team and point of day-to-day information and guidance on child and adult safeguarding for their fellow practitioners. The safeguarding link practitioners meet quarterly to discuss topics and common themes, most recently domestic violence, and learn from case studies. Managers told us that this group acts like an action learning set supporting these link practitioners to gain knowledge and expertise which is helping to strengthen frontline safeguarding practice.
- 5.1.14 CAMHS development of a 0-25 years pathway as required by the Children and Families Act 2014 was at a very early stage.

- 5.1.15 Following the recommendations from the 2011 joint Ofsted/CQC inspection and the recent CQC hospital inspection, RWT had made progress in recruiting to paediatric posts to ensure that a RSCN is on duty within the ED at all times. We were informed that as a minimum there will be two paediatric trained nurses on duty 24/7. This helps to ensure that children and young people are assessed and treated by appropriately trained professionals.
- 5.1.16 Recovery Near You substance misuse service was actively engaged at a strategic level for safeguarding with health and the local authority. This ensured that the support needs of this cohort and related potential for hidden harm to children through substance misuse in adults retained a high strategic profile. The service was also well linked with charities such as Barnardos and the local migrant centre.
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5.2 Governance

- 5.2.1 Operational managers and the Black Country Partnership Trust safeguarding team did not have a picture of the overall numbers of children in adult mental health caseloads nor the cohorts of Early Help Assessment (EHA), CIN or children subject to child protection plans within this total. This was a gap as the trust was unable to fully monitor overall child safeguarding activity and practice over time and operational manager's ability to use this data to inform their practice governance, caseload management and workforce skills profiling was diluted. The named nurse team had identified this as gap and had put it on the trust's risk register. Flagging systems are available on electronic client record systems but these are not being used to aid the visibility of these vulnerable children within mental health services. It is particularly important that the presence of children with known vulnerability is immediately and constantly visible to adult mental health practitioners to ensure their safety and wellbeing is prioritised (**Recommendation 2.7 and 2.13**).
- 5.2.2 Case recording and the management of case records and information systems were areas for development across a number of services. In RWT's midwifery service, the standard of safeguarding record keeping for child protection reports and child protection referrals was variable. There was no quality assurance process in place to oversee the completion or the standard of reports for case conference. The lack of any robust management oversight and quality assurance processes reduces services' ability to raise and sustain good standards of safeguarding practice at the frontline.

- 5.2.3 In midwifery record keeping systems were fragmented, preventing practitioners and managers' access to a complete maternity record that sufficiently identified and analysed safeguarding risk. Community midwives were expected to return to the hospital site to record their contacts into women's hospital records and achieving this promptly was a challenge. In one example the booking home visit was not entered into the hospital records until five weeks after it took place. Again, no process of managerial oversight and monitoring of practice was in place to pick up and address sub-optimal practice or support continuous improvement (**Recommendation 1.20**).
- 5.2.4 The plethora of electronic, paper record and hybrid systems using a combination of both electronic and paper records across services, presents a significant challenge to the effective sharing of, and accessing, information to ensure the safety and wellbeing of vulnerable children. This was a challenge for health visitors and school nurses but particularly evident in the adult mental health service which at the time of the review had five systems operating; hardcopy case records, PC MIS, Oasis, IPM, and Care Notes. One service strand had a hybrid system of partial hard copy records alongside an electronic recording system. These systems did not interface with each other. The trust was very aware of how this was impacting on practitioners' ability to share information across the service effectively and the increased risks of key information being missed or not being immediately accessible to practitioners and managers. We noted plans to move all the Black Country Partnership Trust services to Electronic Health Records (EHR). This would facilitate more effective information sharing and record keeping and should be expedited as soon as possible. The case example observed in the MASH illustrated the potential impact of delays in gaining information from some services due to the use of paper records (**Recommendation 2.14**). *This area for development has been brought to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of health visitor and school nurse services.*
- 5.2.5 Health visitor and school nurse case recording was very descriptive in nature although lacking in some key areas including the home environment, the child's appearance, personality, demeanour and interaction between the parent and child. Recording was not analytical or outcome focused and there was no SMART action planning or routine evaluation of risk (**Recommendation 3.3**). *This area for development has been brought to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of health visitor and school nurse services.*

- 5.2.6 There were capacity pressures in the school nurse service with caseload sizes that exceeded the recommendations from professional bodies. In response to the reduced workforce over school holidays, school nurse safeguarding work was prioritised and a staff rota created to provide cover. While these arrangements were working for the current caseload, the significant reduction in staff over the summer holidays restricts the opportunity to provide a responsive service to other families. *This area for development has been brought to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of school nurse services.*
- 5.2.7 The paper records used by CAMHS were difficult to navigate and locating safeguarding information on the needs and risks associated with individual children was a challenge. Practitioners did not use chronologies of significant events that would aid this and could reflect escalating or de-escalating concerns more effectively to practitioners. Some records were illegible. We also found illegible clinical notes in the RWT ED.
- 5.2.8 Black Country Partnership Trust CAMHS and adult mental health practitioners were required to complete a Datix form when they completing a referral to children's social care. This gives the trust's named nurses the opportunity to quality assure the referral and positive feedback or developmental comments are sent back to the practitioner, helping to support continuous professional development. The trust's governance team operate a weekly telephone conference which reviews all datix entries across the organisation. Operational managers can dial in to participate in this. The trust's safeguarding team was represented at this weekly review until just prior to this review when it was decided that safeguarding was to be viewed as an exceptional issue rather than something to be considered routinely in this review forum. However, positively, this decision was reversed as it was recognised that having the safeguarding team present, ensures that safeguarding issues are identified that may not have been recognised as such in the absence of an expert safeguarding "eye".
- 5.2.9 The BCPT was working towards giving system's access to the safeguarding link workers in the adult mental health so that these practitioners can monitor receipt of outcome notifications from MASH, chase up if not received and then close down datix when appropriate. This would strengthen operational governance and helping to keep the datix system up-to-date facilitating the safeguarding team's monitoring and oversight of current situations or events and referrals.

- 5.2.10 However, there is no provision of operational oversight or checking of the quality of MASH referrals within services prior to them being submitted to the MASH. This issue is not isolated to mental health but was strongly evidenced across most services visited during the review; ED, CASH, health visitors, school nurses and midwifery. By developing robust operational oversight and practice monitoring arrangements for frontline health services, the drive for continuous improvement in safeguarding practice across the Wolverhampton partnership would be significantly enhanced resulting in more effective responses to the needs of children and young people. **(Recommendations 1.21 and 2.15)**. *This area for development has been brought to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of health visitor, CASH and school nurse services.*
- 5.2.11 The provision of a paediatric liaison role in RWT to support governance arrangements in ED, was positive and the role provided a review of safeguarding risk assessment for specific cohorts of young people. However capacity of the role was limited and not all children who attend the ED benefit from having their attendance reviewed by the paediatric liaison nurse **(Recommendation 1.7)**.
- 5.2.12 Leadership and operational governance for child safeguarding was strong at the Recovery Near You substance misuse service. The service manager and team managers had an in-depth picture of all children within their service. A bespoke and interactive data system enabled the service to know exactly how many children are within the service at any one time. The inspector was assured that managers knew their cohort of children and unborn well, including those subject to child protection, CIN, looked-after and those requiring and receiving early help support. This was then further strengthened through the provision of a RAG rating system that alerted both managers and practitioners to the risk associated with each case. This was reviewed monthly. Additionally, the manager dip sampled three case records every 4-6 weeks, to review the quality of practice and this included safeguarding practice.
- 5.2.13 The Recovery Near You service was not using safeguarding chronologies and recognised this as an area for future development. At the time of the review, child protection minutes and MARFs were not scanned onto the case record, but were kept in a separate paper folder. The service recognised that this did not support practitioners well in having all the child's information in one place **(Recommendation 6.3)**.

5.3 Training and supervision

- 5.3.1 While the safeguarding midwife is trained to level four child safeguarding practice, the named midwife, who also had the role of interim head of midwifery at the time of this review, has not undertaken this level of safeguarding training. This is not compliant with intercollegiate guidance and it is essential that staff in managerial and supervisory positions are properly trained and equipped to be able to oversee safeguarding practice effectively; to identify poor practice in order to address it appropriately and to recognise good practice (**Recommendation 1.22**).
- 5.3.2 Midwives have access to ad hoc safeguarding supervision either from the safeguarding midwife or the matron or the trust safeguarding team for concerns they wish to discuss. Formal safeguarding supervision for caseload holding midwives is offered quarterly on an individual basis or in group formats. Hospital midwives access to formal safeguarding supervision is six monthly in a group setting. Ensuring practitioners' comply with these arrangements would give the trust board and the CCG assurance that these arrangements were supporting midwives appropriately but we were not assured that monitoring of the uptake of supervision was in place. Decisions taken in supervision discussions were not being routinely entered onto the woman's case record to ensure they informed the care of the mother and this is not best practice (**Recommendation 1.23**).
- 5.3.3 There was scope to strengthen the midwives' and health visitors' preceptorship programmes. Newly qualified midwifery practitioners are supported by the safeguarding midwife and are expected to complete safeguarding training early into their preceptorship. Newly qualified health visitors undergo a 12 month preceptorship period and are well supported by managers when working with safeguarding cases. However, there are no identified safeguarding competencies as part of the formal preceptorship programme to ensure practitioners demonstrate their knowledge and awareness of good safeguarding practice (**Recommendation 1.24**).

- 5.3.4 ED practitioners have access to single agency level 3 safeguarding training, which is provided by the trust named nurse. It is an on-going challenge to the trust in releasing practitioners to attend multi-agency safeguarding training in line with best practice. At the time of the inspection, the WSCB did not approve or accredited training delivered by other agencies. The learning and development committee of the WSCB currently has on their work plan actions to: support partners in the development of their training packages and to develop an evaluation tool to monitor the quality of single agency training. The timescale for this is Sept – Dec 2017. However a rationale for WCCG safeguarding quality visits has been developed where it is expected that training would be observed prior to the visit. There was no formal structured safeguarding supervision for ED practitioners. Practitioners can attend the clinical peer review meetings but this was recognised as an area needing further development with a more robust approach to ensure practitioners received regular group supervision.
- 5.3.5 Paediatric ward staff had recently had access to some CAMHS training; however it was acknowledged that attendance had been poor. Paediatric ward staff who have expressed a specialist interest in CAMHS had been well supported to access CAMHS degree modules. This was helping to develop expertise in the hospital paediatrics service in caring for young people in mental health distress and at risk of serious self-harm but there was scope to develop this further.
- 5.3.6 The school nurse workforce was reported to be all level three trained in child safeguarding. We received assurance from managers that school nurse safeguarding training was in line with inter-collegiate guidance however, this is provided as single agency training by RWT. Staff have access to external multi-agency training from the LSCB, however, the uptake of this can be variable. (**Recommendation 1.25**). *This has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the school nurse service.*
- 5.3.7 The looked-after children's nursing team had good access to safeguarding training which includes multi agency training. They had been able to attend specific training to meet the needs of the vulnerable children they work with such as CSE and trafficking. Safeguarding training governance was good and managers were informed of non-compliance. However, it was a gap that clinicians undertaking initial and review health assessments for unaccompanied asylum seeking children had not received specific training to properly equip them for this responsibility in fully understanding the experience of the asylum seeking child and the potential impact on health and emotional wellbeing (**Recommendation 1.15**).

- 5.3.8 School nurses can access the named nurse for support on an ad-hoc basis. However, due to their limited capacity, the provision of group and one to one supervision was limited. The trust aimed to provide group safeguarding supervision quarterly and one to one supervision six monthly, but we understood that this was not being achieved. Staff have management reviews and can discuss cases as part of this. In the absence of any robust oversight of safeguarding cases or monitoring of safeguarding practice staff will not benefit from the professional challenge and learning that regular safeguarding supervision can provide. School nurse practitioners have recently started to record when they have discussed cases at safeguarding supervision. This ensures that the practitioner can review and implement any action identified to benefit the child.
- 5.3.9 The interim acting-up named nurse received one to one safeguarding supervision which was well monitored. The ANP was receiving no formal one to one safeguarding supervision to support her in her role and in light of the fact that she was undertaking IHAs routinely, was not acceptable. The named nurse does provide support to the health visitors and school nurses carrying out RHAs but there was no formal supervision arrangement in place to help drive consistent best quality practice (**Recommendation 1.26**). *This has been drawn to the attention of City of Wolverhampton Council Public Health and Wellbeing as the commissioner of the health visitor and school nurse service.*
- 5.3.10 In Black Country Partnership Trust, mental health link workers were being encouraged to undertake training as safeguarding trainers through a five day specialist course and some were undertaking additional training to be able to facilitate team reflective practice sessions. This was due to the named nurse for child safeguarding not having capacity to offer regular group safeguarding supervision which would facilitate reflective practice opportunities although she did offer 1:1 supervision with practitioners on request. The trust's named nurses for children and adults provided periodic Q&A sessions which mental health practitioners and managers across the trust could attend.
- 5.3.11 Safeguarding supervision arrangements in CAMHS and adult mental health were not fully robust overall however. Practitioners were expected to seek supervision on child protection cases through their quarterly clinical and/or managerial supervision. We found case evidence that practitioners were not always compliant with this policy. supervision did not include CIN cases however; nor did it include a routine review of cases held to ensure no child safeguarding risks had been overlooked (as we identified in an adult mental health case) and was practitioner rather than operational manager led. Without good knowledge of what EHA, CIN, and child protection cases there are in CAMHS and adult mental health, it is difficult for operational managers of these services to ensure practitioners are receiving appropriate supervision and that safeguarding practice is fully and effectively supported (**Recommendation 2.9**).

- 5.3.12 Health visitors had access to six monthly group supervision, and in addition 1:1 supervision during the six months as and when need was identified by the practitioner.
- 5.3.13 Other than in the Recovery Near You adult substance misuse service, practitioners in health provider services were not routinely recording in the case record that the case has been discussed in supervision neither were decisions made as a result of discussions in supervision being properly or routinely recorded in the child's or adult's record (**Recommendations 1.27 and 2.16**).
- 5.3.14 Level three safeguarding training for practitioners in Recovery Near You needed further review, Compliance was monitored against an expectation of a half day every three years following two days safeguarding induction. Throughout the three years, practitioners were able to attend multi agency training for thematic topic training and had completed CSE and FGM training. There had recently been in-house training on domestic violence. However, the service was not actively monitoring to ensure that every practitioner needing level three competency were undertaking the required 12-16 hours over three years (**Recommendation 6.4**).
- 5.3.15 The Recovery Near You supervision offer was robust. Practitioners received one to one supervision on a 4-6 weekly basis which included case discussion and compliance was closely monitored. A multidisciplinary team meeting was held monthly as a form of group supervision to discuss cases.

Recommendations

- 1. Wolverhampton CCG and The Royal Wolverhampton NHS Trust should:**
 - 1.1 Ensure that midwifery practice and compliance with trust policy is subject to effective operational management governance and monitoring
 - 1.2 Ensure that risk assessment in the midwifery service is comprehensive and robust; well supported through the use of appropriate assessment tools
 - 1.3 Ensure that effective facilities and measures are in place to enable any deterioration in a child's medical condition or concerns about interactions between a child and their parent/carer can be easily identified and responded to promptly
 - 1.4 Ensure that appropriate protocols are in place to govern the examination of pre-mobile infants in line with best practice and NICE guidance
 - 1.5 Put in place documentation in adult and paediatric ED that supports staff in undertaking effective safeguarding risk assessments and which is subject to managerial oversight and monitoring to ensure good risk assessment practice becomes embedded
 - 1.6 Ensure that staff in adult ED are effective in their identification of the "hidden child" and any potential safeguarding risks to that child arising from risk taking behaviours of adults
 - 1.7 Ensure that robust systems and processes are in place that minimise risk that safeguarding vulnerabilities and risks to under 18s attending the ED, including the hidden child, may be overlooked
 - 1.8 Ensure that decisions or agreed ante-natal actions arising from meetings and communication between midwives and Recovery Near You are recorded in the patient's records and care plans to inform practice and reduce risk
 - 1.9 Ensure that midwifery management infrastructure and specialist roles are recruited as substantive posts and that strategic development and improvement of maternity safeguarding practice and practice governance is fully and effectively supported
 - 1.10 Ensure that looked-after children who are expectant mothers-to-be are well supported in a multi-agency team around the child approach

- 1.11 Ensure that operational managers routinely quality assure referrals to MASH in order to best support practitioners' articulation of risk of harm to the child and facilitate optimum MASH decision making in regards to intervention
- 1.12 Ensure that there are robust arrangements in place in midwifery services so that all practitioners and clinicians are fully informed of known risks to unborn, new-borns and mothers to ensure the vulnerable are safeguarded effectively
- 1.13 Work with City of Wolverhampton Council to ensure the child protection antenatal and post-natal pathway is robust and subject to effective managerial governance
- 1.14 Ensure that initial health assessments are undertaken by appropriately qualified clinicians in line with statutory guidance and in a timely way
- 1.15 Ensure that initial and review health assessments of unaccompanied asylum seeking children (UASC) have appropriate interpreting support and are undertaken by appropriately qualified clinicians and practitioners who have undertaken specific training on the asylum seeking experience
- 1.16 Work with the City Of Wolverhampton Council children's social care to ensure that looked-after children health records are complete and comprehensive and subject to effective quality assurance
- 1.17 Ensure that relevant health professionals involved with the looked-after child; GPs and CAMHS are invited to contribute to inform the child's initial and review health assessment and that the resultant assessment and health plan is shared appropriately
- 1.18 Ensure that young people who are care leavers have comprehensive health histories, including information on parental health history and why they came into care and are well supported by health services as they become adults
- 1.19 Ensure that there is sufficient capacity in the safeguarding team to provide effective leadership, supervision and governance across the trust's services to drive and support continual safeguarding practice improvement
- 1.20 Ensure case records are up to date and comprehensive and subject to effective managerial oversight
- 1.21 Ensure there is effective quality assurance and managerial oversight of referrals made to the MASH prior to submission in order to best support continuous practice improvement within services and facilitate optimum decision making in the MASH

- 1.22 Ensure that all practitioners, supervisors and managers undertake the appropriate level of child safeguarding training commensurate with their roles and responsibilities
 - 1.23 Ensure that midwives uptake of supervision is monitored and that decisions and actions resulting from case discussion in supervision forums are entered onto the patient record
 - 1.24 Ensure that newly qualified practitioners are best supported to develop excellent safeguarding practice early in their careers through the inclusion of measurable safeguarding competences in preceptorship programmes
 - 1.25 Ensure that school nurse practitioners have undertaken multi-agency safeguarding training at level 3 in line with best practice and commensurate with inter-collegiate guidance
 - 1.26 Ensure that there are robust supervision arrangements in place for clinicians and practitioners including those involved in assessing and meeting the health needs of looked-after children
 - 1.27 Ensure that where cases are discussed in group or one to one supervision, decisions and outcomes from these discussions are recorded on the client record in line with NICE guidance and best practice
- 2. Wolverhampton CCG and Black Country Partnership NHS Foundation Trust should:**
- 2.1 Ensure that young people have prompt access to mental health services and, if waiting for intervention, that they are supported to minimise the risk of a deterioration in their mental wellbeing
 - 2.2 Ensure that the potential for risk of child sexual exploitation (CSE) is routinely assessed by CAMHs practitioners using appropriate assessment tools
 - 2.3 Work with partners to develop and establish an effective specialist perinatal mental health pathway in line with NICE guidance
 - 2.4 Ensure regular liaison with health visitor and school nurse services is becoming embedded and practitioners share relapse indicators, recovery action and contingency plans with other professionals as routine practice to strengthen team around the family practice
 - 2.5 Ensure that operational managers routinely quality assure referrals to MASH in order to best support practitioners' articulation of risk of harm to the child and facilitate optimum MASH decision making in regards to intervention

- 2.6 Ensure that the adult mental health Did Not Attend protocol and flowchart takes into consideration any potential risks to the child or unborn as a result of the non-attendance of the adult
 - 2.7 Ensure that electronic flagging systems are used and maintained effectively in CAMHs and adult mental health to alert practitioners and managers to cases where there are known to be risks to children and young people
 - 2.8 Ensure that CAMHs and adult mental health practitioners attend and submit written reports to child protection case conferences in advance and record outcomes promptly in case records in line with best practice
 - 2.9 Ensure that practitioners in CAMHS and adult mental health are well supported in discharging their safeguarding responsibilities through robust supervision arrangements
 - 2.10 Work with the City of Wolverhampton Council to develop an effective pathway for inviting mental health practitioners to attend Child in Need and child protection meetings
 - 2.11 Ensure that practitioners assess routinely for risks of CSE using appropriate assessment tools and are well engaged in multi-agency arrangements in individual cases
 - 2.12 Ensure that children who are looked after and who have emotional or mental health needs can access CAMHs in a timely way
 - 2.13 Put systems and processes in place to ensure that adult mental health operational managers understand the cohorts of vulnerable children on caseloads and use this data to strengthen operational oversight and governance arrangements
 - 2.14 Ensure that client information systems are rationalised, are electronic and fit for purpose within an agreed timescale
 - 2.15 Ensure there is effective quality assurance and managerial oversight of referrals made to the MASH prior to submission in order to best support continuous practice improvement within services and facilitate optimum decision making in the MASH
 - 2.16 Ensure that where cases are discussed in group or one to one supervision, decisions and outcomes from these discussions are recorded on the client record in line with NICE guidance and best practice
- 3. The Royal Wolverhampton NHS Trust should:**
- 3.1 Ensure that engagement with vulnerable children and families and delegation of tasks to health visitor support workers is subject to effective risk assessment and subject to managerial oversight and monitoring

- 3.2 Ensure that action plans and outcomes arising from vulnerable family liaison forums with GPs are properly recorded on health visitor records in order to inform day-to-day practice
 - 3.3 Ensure through managerial oversight and monitoring that health visitors routinely and effectively assess maternal mood and domestic abuse and record outcomes
 - 3.4 Ensure that school nurse assessment of young people's emotional wellbeing is underpinned by the routine use of robust risk assessment tools
 - 3.5 Put systems and processes in place to ensure case planning and recording in health visitor and school nurse services is comprehensive, analytical and outcome focused and subject to effective managerial oversight and governance
- 4. Wolverhampton CCG should:**
- 4.1 Work with partners to put in place an effective 0 – 25 pathway for young people with ASD and ADHD as part of the developments required by the Children and Families Act (2014)
 - 4.2 Work with the Black Country Partnership NHS Foundation Trust and the Royal Wolverhampton NHS Trust to raise awareness and understanding across services of the potential long-term harm to the health and wellbeing of children living with domestic abuse
- 5. NHS England and Wolverhampton CCG should:**
- 5.1 Work with GPs and The Royal Wolverhampton NHS Trust to establish regular vulnerable family liaison forums in primary care in line with the service level agreement and best practice
- 6. Recovery Near You should:**
- 6.1 Ensure regular liaison with health visitor and school nurse services is becoming embedded and practitioners share relapse indicators, recovery action and contingency plans with other professionals as routine practice to strengthen team around the family practice
 - 6.2 Ensure that practitioners attend and submit written reports in advance to child protection case conferences in line with best practice
 - 6.3 Ensure that client case records are comprehensive; inclusive of all key child protection documentation and any referrals to the MASH in line with NICE case recording and records management guidance

- 6.4 Put effective monitoring arrangements in place to ensure that practitioners undertake the required hours of multi-agency safeguarding training to best support optimum safeguarding practice across the service
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Next steps

An action plan addressing the recommendations above is required from Wolverhampton 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.