

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

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

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CCGs included:	Leicester CCG West Leicestershire CCG East Leicestershire CCG
NHS England area:	East Midlands Region
CQC region:	Central - Midlands (East)
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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 Leicestershire. 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 Leicestershire, 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 Children's 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 2018.
- 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 Children's 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 56 children and young people.

Context of the review

Children and young people under the age of 20 years make up approximately 22.7% of the population of Leicestershire. In comparison to the rest of England, the population of children and young people is likely to be less, although there has been a recent spike in young adults aged between 20-24 in the county which can be attributed to an increase in the student population.

Approximately 91 per cent of the county's population belong to white ethnic groups. This is slightly higher than the East Midlands and England average. The next largest ethnic minority group in Leicestershire is Asian (6.3 per cent) and a further 1.7 per cent of children young people and families are from black ethnic minority groups. In Leicestershire, 17.6 per cent of school age children are from an ethnic minority group.

Leicestershire is a predominantly affluent and rural county, and generally is not an area of deprivation. However, there are some pockets of deprivation in the localities of Loughborough and Coalville which fall into the most deprived decile in England.

On the whole, the health and wellbeing of children in Leicestershire is generally better compared with the England average, with lower levels of obesity, teenage pregnancy and accidental injury. Infant mortality rates in Leicestershire fall slightly below the comparative value for England. The rate of hospital admissions for young people living in the county is a particular area of strong performance, with fewer children and young people being admitted due to alcohol misuse, substance misuse and due to self-harm.

The DfE reported that Leicestershire had 324 looked after children that had been continuously looked after for at least 12 months as at 31 March 2017 (excluding those children in respite care). Whilst the numbers of looked after children in Leicestershire are lower than national and regional figures, there has been, as nationally, a year on year increase in the number of children who become looked after since 2010. There has also been an increase in the number of unaccompanied children recorded as seeking asylum year on year for the past three years.

A strengths and difficulties questionnaire (SDQ) is used to assess the emotional and behavioural health of looked after children within Leicestershire. The most recent SDQ score (2017) was 16.9 compared to the England value of 14.1. The average score has increased since 2015, this suggests that the emotional health and wellbeing of looked after children in Leicestershire may be deteriorating.

Commissioning and planning of most health services for children is carried out by Leicester City Clinical Commissioning Group (LCCCG). During 2017/18 the three CCG's across Leicester, Leicestershire and Rutland (LLR) agreed a proposal to develop a joint management structure across West Leicestershire CCG, East Leicestershire and Rutland CCG and Leicester City CCG. Across LLR, each of the CCG's takes the lead on certain areas of work on behalf of the other two CCG's, and Leicester City CCG has the responsibility for children's services.

The majority of residents in Leicestershire (52.4%) are registered with a GP practice that is a member of NHS West Leicestershire Clinical Commissioning Group (WLCCG), whilst a further 39.7% are registered with practices that fall under East Leicestershire and Rutland CCG. A very small percentage are registered with other GP's that fall under other CCGs.

Acute hospital services are commissioned by Leicester City CCG and are provided by University Hospitals of Leicester NHS Trust (UHL). Acute services are also commissioned from Queen's hospital Burton, and George Eliot hospital Nuneaton. Our review included visits to the emergency department (ED) at Leicester Royal Infirmary (LRI), children's short stay unit and maternity services at both LRI and Leicester General Infirmary (LGI).

Health visitor services are commissioned by Leicestershire County Council Public Health and provided by Leicestershire Partnership NHS Trust (LPT).

School nurse services are commissioned by Leicestershire County Council Public Health and provided by Leicestershire Partnership NHS Trust (LPT).

There are three CCG's that work collaboratively to provide services for children and young people living in Leicestershire. Commissioning arrangements for looked-after children's health are the responsibility of Leicester City Clinical Commissioning Group, on behalf of West Leicestershire CCG and East Leicestershire and Rutland CCG) The looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by Leicestershire Partnership NHS Trust (LPT).

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

Maternal and mental health services are provided by Leicestershire Partnership NHS Trust.

Contraception and sexual health services (CASH) are commissioned by Leicestershire County Council Public Health and provided by Midlands Partnership NHS Foundation Trust.

Adult mental health services are provided by Leicestershire Partnership NHS Trust. Adult substance misuse services are commissioned by Leicestershire County Council Public Health and provided by Turning Point.

Child substance misuse services are commissioned by Leicestershire County Council Public Health and provided by Turning Point.

The last inspection of services for children in need of help in Leicestershire took place in December 2016 and was carried out by Ofsted. The overall effectiveness of the safeguarding services including for looked after children was judged as **requires improvement**, whilst the effectiveness of the Local Safeguarding Children's Board (LSCB) was rated as **good**. Progress against inspection recommendations have been considered in this review.

The report

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

What people told us

One young person in care told us:

“I wish I could see my nurse more. When I do, it is really good. She does listen and help me.”

One care leaver told us:

“It is like when you become an adult you don't matter. I had some issues with my mental health, started to feel down and that, but by the time you get support with it, your problems have got worse.”

One young person who had been subject to multiple CP plans told us:

“Once I found a therapist who really helped me. She tried to understand the reasons why I behaved the way I did. Nobody had done that before. I really opened up to her and then she left (CAMHs) as the funding for her job stopped. People expected me to keep telling my story and it is painful to do that, so when I was quiet they would say I wasn't engaging with them.”

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 Children and young people who attend the paediatric emergency department (ED) at Leicester Royal Infirmary (LRI) benefit from care delivered in a newly built facility that has been thoughtfully designed to meet the needs of children. Those aged over 16 are generally seen in the adult emergency department, unless they have a long-term health condition or additional needs such as a learning disability. Young people aged over 16 are not given the option to be seen in paediatric ED.

1.2 Good arrangements are in place to book children into ED. All children and young people who attend ED are booked in at the main reception desk (a shared booking point for all patients) and are then asked to wait in the main waiting room for triage. After triage, which is carried out by a registered children's nurse, children are transferred to a dedicated children's waiting room. Whilst waiting for treatment, a qualified paediatric nurse carries out visual assessments of all children and young people and assigns them with a Dynamic Priority Score (DPS). This scoring system helps clinicians prioritise which children they treat first. DPS scores are reviewed at regular intervals which enables staff to detect those children and young people who may be deteriorating, so that they can be attended to swiftly. Regular observations also enable staff to monitor interactions between the child and the adults that are accompanying them.

1.3 Children and young people who attend ED and who are cared for on paediatric wards may not always be cared for by clinicians who have attended safeguarding level 3 training as recommended by the royal colleges intercollegiate guidance. The trust has an ambitious target of 95% to ensure that those clinicians and staff across the trust are trained appropriately and they are working hard to achieve this. There are capacity issues in paediatric medical and nursing teams. High levels of registered nurse vacancies in paediatric ED and on paediatric wards has resulted in reliance of bank and agency staff to cover staffing shortfalls. University Hospitals of Leicester NHS Trust (UHL) have acknowledged staffing is an area of concern, and gaps in the availability of paediatric staff feature on the Trust's risk register. Priority is being given to the recruitment and retention of suitably skilled and qualified clinicians, however staffing and capacity within these areas had not been fully addressed at the time of this inspection. (**Recommendation 2.1**)

1.4 Clinicians in ED are not routinely making referrals to the Turning Point substance misuse service to ensure that young people who have attended ED due to misusing substances or alcohol benefit from on-going specialist support post discharge. This is an area of development as the opportunity for specialist services to respond to emerging concerns regarding substance misuse in young people is being missed. *This has been brought to the attention of Public Health.*
(Recommendation 2.2 and 5.1)

1.5 Communication between ED and community health professionals such as health visitors and school nurses is not always timely and robust. Once a child or young person is discharged from ED, the electronic patient record system sends an automatic alert to the child's GP which alerts them to the recent ED attendance. There is a paper based paediatric liaison form that is completed to inform health visitors and school nurses when a child or young person has presented at ED. However, community health professionals are only alerted and informed of admissions when significant risks have been identified, and there may be a delay in when this information is received. As health visitors and school nurses are not alerted to every admission, this may hinder their ability to identify children and young people who may be in need of early help and support. The local area were unable to demonstrate to inspectors that these arrangements were robust and that opportunities to intervene had not been missed. **(Recommendation 1.15, 2.10 and 4.1)**

1.6 Arrangements to identify vulnerability and risk to women and unborn babies are strong. The majority of pregnant women in Leicestershire chose to self-refer and opt to use maternity services provided by University Hospitals of Leicester NHS Trust (UHL). Midwives are carrying out effective assessments of vulnerability when booking women's pregnancies. The hand-held notes are be-spoke to Leicestershire and prompt midwives to sensitively enquire about domestic violence and abuse on at least three occasions during pregnancy. The hand-held notes also facilitate midwives to capture information regarding family composition and linked children, including where children previously associated with the family now live.

1.7 Midwives are ensuring that all women are asked in a culturally sensitive way during routine enquiry if they have been subject to, or are at risk of, Female Genital Mutilation (FGM). Additional risk assessments are also carried out for women who are identified as being at enhanced levels of risk or who are in need of additional support.

1.8 Families with children under 5 years of age benefit from a co-ordinated approach to identifying and responding to risks and vulnerabilities. Liaison and joint working between midwives, health visitors and GPs was effective and further supported by shared use of an efficient electronic patient record system. The use of SystemOne supports timely and efficient information sharing across primary care and community health teams, and supports the co-ordination of care. Health visitors are an integral part of the Early Help offer and are routinely referring families to children's centres and to GPs where they can receive early help and support to meet their needs.

Child A was known to a number of agencies and services including children's social care, CAMHs and the public health school nursing service. Child A's family composition was complex, and a number of children were part of Child A's immediate and extended family.

Practitioners had identified several presenting concerns, including intra-familial sexual abuse, mental health issues and domestic violence. Good multi-agency and liaison and joint working with health professionals, children's social care and schools ensured that appropriate safeguarding measures were in place to support Child A and to prevent the child from being exposed to any further incidents of harm or abuse.

Regular multi-professional liaison also resulted in good identification of the risks that children in Child A's wider family unit may be exposed to, and professionals worked well together to ensure that these risks were mitigated against and that these children were in receipt of effective early help.

1.9 Health visitors are working holistically with families and demonstrated that they are alert to factors such as levels of literacy and cognitive understanding. Health visitors flexibly adapt their approach when working with families who require additional help and support and we heard how this flexibility helps to promote and support parental engagement with the health visiting service

1.10 Effective delivery of the Healthy Child Programme in Leicestershire is ensuring that children at risk of neglect, abuse and harm, with low protective factors are being provided with early help and support that they need to reduce the likelihood of harm and health inequalities. Health visitors are working holistically and collaboratively with families to promote the HCP, and this is producing high levels of parental engagement.

1.11 Transitional arrangements from the health visiting service into school nursing teams are robust. Face to face handovers take place between school nurses and health visitors in cases where the child has identified additional needs and vulnerabilities. This process ensures that the school nurse is fully informed and alerted to the risks and needs of the child.

1.12 There is a good commissioned school nursing offer in Leicestershire which includes a range of 'drop-ins' for primary and secondary schools, the ChatHealth instant messaging service, and the National Child Measurement Programme. There has also been a recent roll out of the young person's online survey, which provides good opportunities to identify and respond to the individual concerns of the young person, but also for the wider needs of Leicestershire's school age population to be met. School nurses are consistently sharing information effectively and health records reviewed demonstrated good joint working with other health professionals and multi-agency colleagues.

1.13 Despite this practice, children, young people and families who require early help are not always being identified at the earliest opportunity by school nurses. Records reviewed demonstrated that the use of professional curiosity, the analysis and exploration of risk and the voice of the child was inconsistent and therefore some children and families may experience a delay in receiving help and support if their needs are not identified in a timely way. *This issue has been drawn to the attention of public health. (Recommendation 1.2)*

1.14 Whilst the commissioned school nursing offer is strong, children and young people's access to school nursing is variable across Leicestershire, and opportunities to identify and respond to families who may require additional early help and intervention in some localities is reduced; the ability to provide the full offer consistently across Leicestershire has been affected by significant capacity issues. Leicestershire's school age population is covered by eight locality teams, however due to staffing vacancies, three of the eight teams are operating a 'prioritisation model'. In localities where prioritisation models are in effect, school drop ins for parents and pupils and school health profiles are suspended, and the opportunity to identify children and families who are in need of early help are reduced. *This issue has been drawn to the attention of public health. (Recommendation 1.1)*

1.15 Health professionals who are working with children who have emerging mental health needs can access support and guidance from the CAMHs telephone advice service. The professional advice and support is well regarded by professionals who told us that the practical advice they received has helped them to provide enhanced levels of support and has helped equip them with skills to ensure that children and young people with mental health and emotional health and wellbeing needs remain engaged with services.

1.16 Contraception and sexual health services (CASH) are widely available and well used across Leicestershire, and we saw evidence of strong partnership with other agencies and providers to ensure that vulnerable young people were supported and kept safe. Practitioners are carrying out effective screening to ensure that children and young people in need of early help have receive appropriate support and interventions in a timely way.

2. Child in need

2.1 Children who present to paediatric ED who have mental health and emotional health and well-being needs benefit from the availability of segregated areas and specialist cubicles which have been designed to minimise distress. These facilities have been of benefit to children and young people who are in mental health crisis or have additional sensory needs. In some cubicles, shutters can be deployed to ensure that there are no ligature points accessible and that sensitive equipment is kept from reach which helps keep children with additional vulnerabilities safe from avoidable harm. Staff are also well skilled to respond appropriately to children and young people presenting with mental health needs.

2.2 Identification of the needs and vulnerabilities of adolescents that present in ED is not effective. Whilst we were told that there is a safeguarding screening tool for older children and adolescents, we saw no examples of where this tool had been used. The adult safeguarding screening tool does not contain appropriate age-related prompts, for example questions relating to child sexual exploitation (CSE). In some of the records viewed, there was a lack of professional curiosity and little explanation of the young person's current circumstances and reasons behind their attendance. Records are not being audited, and therefore potential incidents of abuse, needs and vulnerabilities may be missed. (**Recommendation 2.3**)

One young person that we spoke with who had been treated in adult ED told us;

“Once I had to go to adult ED. Nobody bothered to ask anything about me, nobody asked if I was okay and nobody knew my history. I have been on child protection plans loads of times in my life but it was like nobody was bothered if I was safe.”

2.3 Vulnerable women living in Leicestershire benefit from a partnership approach to their care. Specialist midwives have good links with midwives in hospitals and in the community, but also have well-embedded relationships with other community health teams. For example, we heard that the specialist mental health midwife provides support to community midwives and adult mental health practitioners. This enables them to support women with mental health needs in the community, decreasing the need for admission to a mother and baby unit. The substance misuse specialist midwife also works in close partnership with Turning Point, the substance misuse service, to support pregnant women in reducing the harm to her unborn baby which may result from her substance misuse.

Woman B became pregnant by her partner and was referred to the crisis team by her GP as she had informed her doctor that she was experiencing ideation and thoughts about killing her unborn baby. She had a 4 year old child at home, and a long history of mental health issues which had recently deteriorated as a result of her ceasing to take her medication due to becoming pregnant.

She was immediately placed on the waiting list for the specialist peri-natal mental health service and whilst on the waiting list benefitted from daily home visits from the crisis team who completed detailed analysis of risks to the mother, her child and unborn baby. The situation was successfully risk managed and stabilised quickly before the perinatal mental health team commenced treatment.

2.4 The peri-natal mental health service provided by the Leicestershire Partnership Trust (LPT), is benefitting pregnant women in Leicestershire who have mental health needs. Whilst there is an average wait of four weeks for women to access this service, women on the waiting list are supported by practitioners from the adult mental health crisis team. Liaison and information sharing between adult mental health and the peri-natal mental health team is effective, and joint working and observations of women who are waiting to access specialist peri-natal mental health support ensure that risks are monitored and prevented from escalating.

2.5 Timely information sharing ensures that risks that may impact on babies once they are born are communicated by midwives to health visitors at the earliest opportunity. Joint home visits are carried out when required which provide care continuity, and has helped to strengthen parental engagement with the health visiting team. Records viewed demonstrated good documentation of home visits, and health visitors are making detailed observations of parental engagement and interactions with the child. Detail of the child's responses to their parents, their lived experience and how well their needs are being met was also clearly considered and recorded in health visiting records.

2.6 Additional funding and priority has been given to ensure that a significant number of improvements are made to the CAMH service. Whilst this service is on a clear trajectory of improvement, and changes made to the specialist CAMH service now means that children with more complex needs are receiving a more focused and holistic service, the core CAMHs offer is fragmented, and too many children are waiting too long to access support. Practitioners at an operational level told us that they find it difficult to decide what part of the CAMH service would best meet the presenting needs of the child and are confused by the multiple and complex care pathways. (**Recommendation 1.3**)

2.7 Practitioners from CAMHs play an active and important role in supporting children in need in Leicestershire. We saw evidence of frequent and regular attendance at child in need meetings and agreed activity which is part of a child in need plan being carried out by CAMHs clinicians. Contributions from CAMHs to the child in need process, ensures that children and young people's mental health and emotional well-being are considered as part of the wider picture of need and result in more holistic and meaningful child in need plans being produced.

2.8 Children and young people who are hard to reach or difficult to engage are benefitting from improved accessibility to CAMHs. CAMHs practitioners in the Young Person's Therapy (YPT) team are working flexibly and holistically with children and young people that are in need of mental health support but who are hard to reach and difficult to engage. Young people who may not otherwise access CAMHs support or who may feel uncomfortable receiving interventions in a clinical setting are benefitting from meeting with mental health practitioners in residential children's homes or in other environments in which they feel safe, secure and comfortable

2.9 Care plans reviewed in CAMHs are successfully capturing the voice of children and young people as they are comprehensive, outcome focused and written in collaboration with children and young people. In records examined, the wishes and feelings of children and young people were prominent, and demonstrated that children and young people were active participants in their care planning.

2.10 Children and young people who do not attend their scheduled CAMHs appointment are not discharged from the service until practitioners have explored the reason for disengagement or non-attendance. Analysing the reasons for non-attendance is supporting front line practitioners to tailor appointment locations and times to encourage young people who require support to engage with the service. Whilst this approach prevents children and young people who miss appointments from having to be re-referred into treatment, some of the cases we reviewed were then subject to drift and delay, as there is not an embedded and consistent approach to tracking cases where children have not been brought to appointments or have disengaged from treatment. (**Recommendation 1.4**)

2.11 The embedded and strong “Think Family” ethos in the adult mental health service is ensuring that vulnerable children and young people who are linked to service users are being effectively safeguarded. Additional and detailed risk assessments are completed for adult service users who are in contact with children and young people. Risk assessments examined were dynamic and continual, and had a good focus on the needs and vulnerabilities of children in the home. The cases reviewed, demonstrated that children were well considered in care plans, and practitioners would regularly seek additional discussions and advice from the safeguarding team, on how best to support these identified children. We also found evidence of practitioners regularly contacting other agencies such as school nursing and children’s social care to ensure that children of service users affected by mental health issues had their needs recognised and met.

2.12 Parents who are admitted as an inpatient to receive treatment for their mental health conditions are able to have regular contact with their children due to the availability of family rooms on in-patient wards. Adult mental health practitioners carry out effective observations of family dynamics and interactions during contact sessions and use elements of the neglect tool kit to determine risk factors that the child may potentially be exposed to when their parent is on home leave or is discharged. Findings from observations are clearly documented in patient records, and are used to inform robust risk assessments which help to mitigate identified risks to children and young people.

2.13 Turning Point also has a strong “Think Family” focus, and practitioners have a good understanding of the impact that parental substance misuse has on children and young people. The electronic client record system captures demographic details of children, including the school that the child attends. This enables the practitioner to make contact with the child’s school to alert them to the fact that parental substance use is a risk factor and that the child may benefit from additional support. Genograms are automatically generated for each client and flags on the electronic client record system alerts the practitioner when there are safeguarding concerns and when there is a child present in the family home.

2.14 All adults who attend Turning Point for treatment who have contact with children, are provided with a medicine storage box where their prescribed drugs and sharps can be stored safely and out of the reach of children. A flag is placed onto the system when a safe storage box has been issued. Home visits are also routinely carried out which provides the practitioner with an opportunity to ensure that the home environment is safe and suitable for children.

2.15 General Practitioners (GPs) from the two practices that we visited are not involved in the child in need process. We were told that invites to child in need meetings are not being received, and that on the rare occasion that an invite has been received, there has not been enough notice given to allow the GP to attend. This limits the GP who is the primary record holder to contribute the information that they have about the child to the meeting. Some GPs may have been the child's family doctor for a significant period of time, and therefore have been in a position which has allowed them to obtain a longitudinal view of the child, their family and a good understanding of associated risks and vulnerabilities. (**Recommendation 4.3**)

3. Child protection

3.1 All referrals to children's social care are made to the "First Response Team". Effective arrangements are in place to ensure that information from health practitioners is received quickly by social workers whom facilitate timely discussion and decision making. Leicestershire Partnership NHS Trust have established a "golden number", an advice line and link to a database, which enables social workers to obtain the details of the health visitor, school nurse and other key health professionals that are supporting the families who are the subject of referrals. Links with health and social care are good, and the majority of practitioners that we spoke to across the health economy told us that they are invited to participate in strategy and child protection meetings.

3.2 Recent changes in organisational processes at Leicester Royal Infirmary (LRI) are enabling children and young people in mental health crisis to receive timely assessments from the all age mental health liaison team. The assessments that we examined were of an exceptionally high quality, and evidenced that practitioners were carrying out detailed analysis of risk. There are effective and well embedded links with the mental health practitioners in LRI and the CAMHs crisis intervention and home treatment team. Joint working is enabling children and young people who do not have a co-existing medical need to be discharged from hospital, but with a clear plan in place that keeps them safe from further harm and ensures that their identified needs are met. These arrangements are helping to reduce the need for inpatient admissions to CAMHs Tier 4 units.

3.3 The UHL safeguarding team have effective and robust processes in place to record and track safeguarding activity across acute and emergency services. All safeguarding activity is uploaded and recorded onto a live spreadsheet which is then in turn uploaded onto the electronic notes system. These processes ensure that clinicians and staff are well sighted on the needs and vulnerabilities of their patients. The use of the trust “traffic light” system is facilitating clinicians to identify risks and clear guidance is in place to support staff in deciding what is the most appropriate action to take in response to the levels of risks identified and to safeguard effectively.

We saw evidence of concerns being closely monitored in the acute setting to ensure that actions are undertaken to appropriately safeguard children and young people.

On the day of our inspection visit, we saw one example of a case being referred to the UHL safeguarding team from the fracture clinic, as it had been identified that the child had not been brought to two follow up appointments.

The safeguarding team promptly contacted the child’s school who informed them that the child had poor school attendance. This prompted a discussion with the child’s school nurse, and this information was immediately shared with children’s social care.

3.4 Arrangements to identify the dependants and children associated with adults who attend ED are weak. The local area has conducted some analysis of recent serious case reviews, and have identified that health practitioners need to be more aware of the potential risks posed to children by adults who affected by mental ill health, domestic violence and substance misuse. However, the adult mental health pro-forma does not prompt clinicians to explore if the presenting adult has any dependants or access to children, and therefore any potential risk which the adult may pose to children may not be identified or responded to. (**Recommendation 2.4**)

3.5 The Child Protection Information System (CP-IS) has not yet been implemented at Leicester Royal Infirmary and therefore clinicians and staff may not be alerted to when a child is looked after, known to children’s social care or subject to a child protection plan. This gap is acknowledged by the CCG and the Trust and is highlighted on both risk registers. Process has been made to ensure that CP-IS will be launched and implementation is planned by the end of 2018. (**Recommendation 2.5**)

3.6 There is a good range of specialist midwives, including specialist midwives for substance misuse, teenage mothers, mental health and for homeless and asylum-seeking women. Outreach and home visits are offered to women which promote engagement antenatally and postnatally, and provides specialist midwives with the opportunity to observe the home environment of mother and baby. We saw evidence of the specialist midwifery team completing robust risk assessments which resulted in detailed multi-agency plans. This strong specialist midwife offer ensures that vulnerable women and babies with the most complex needs are safeguarded.

3.7 Good arrangements are in place to ensure timely follow up of pregnant women who do not attend arranged ante-natal appointments. A home visit is triggered if a woman does not attend three ante-natal appointments and midwives are tenacious in ensuring that expectant women are seen regularly during the antenatal period therefore, protecting the health and wellbeing of the pregnant woman and unborn child.

3.8 Record keeping in maternity is fragmented as two electronic patient record systems and a paper based system is in use. The most detailed and comprehensive safeguarding information, including pre-birth plans, is stored on the safeguarding electronic record keeping system, to which only the Trusts two safeguarding midwives have access. When these midwives are not available after hours, midwives may not have a full history and picture of women's risks and vulnerabilities, which may hinder their ability to appropriately manage identified risks and appropriately safeguard vulnerable mothers and babies. (**Recommendation 2.6**)

3.9 Community and hospital midwives are not routinely making direct referrals to children's social care, and current arrangements are resulting in unnecessary delays in identified risks being responded to. If midwives are concerned about a case, they are required to make a referral to the safeguarding midwives. Referrals are then triaged, and the safeguarding midwives decide if the level of concern identified should trigger a referral to children's social care. (**Recommendation 2.7**)

3.10 The early start health visiting programme is providing enhanced levels of support to parents and families where safeguarding concerns and risks have been identified. This is providing increased opportunities to monitor and respond appropriately to risk. Health visitors are holistically addressing presenting safeguarding factors which may impact on parental capacity and are adopting a "whole family safeguarding approach". This support is offered from 16 weeks gestation and continues until the child reaches two years of age, which enables health visiting practitioners to develop a longitudinal view of vulnerable families.

3.11 Children's with additional risks and vulnerabilities are well safeguarded by health visitors. Health visitors are utilising a wide range of assessment tools which are enabling them to identify and analyse risk. We saw evidence of DASH assessments being used to identify the presence of domestic violence and abuse, and the roll out of the neglect tool kit and training has helped to develop a shared approach with children's social care to ensure that where neglect is a factor, it is identified and appropriately responded to. The use of Ages and Stages Questionnaires (ASQs) have also helped identify issues that require prompt multiagency support and intervention.

3.12 Observations and findings from risk assessments completed by health visitors are clearly documented in reports that are prepared for children protection conferences. The records and reports examined were of a consistent high standard. We saw evidence of health visitors being regularly invited to participate in child protection conferences and attendance was consistently good.

3.13 Chronologies and genograms to aid practitioners understanding of complex family compositions, and significant events are not routinely being used by midwives, health visitors or school nurses. We were told by several practitioners from these health disciplines that they are working with an increased number of complex and extended families. Findings from Serious Case Reviews nationally, and reports into the care of children and vulnerable adults, have concluded that chronologies could have better supported the earlier identification of the risks to children and vulnerable adults (**Recommendation 1.5 and 2.11**)

3.14 Children and young people in Leicestershire are benefitting from effective multi-agency working. School nurses and CAMHs practitioners are also being routinely invited to and are participating in strategy meeting and to child protection conferences to discuss children and young people who are particularly vulnerable or at risk. Risk assessments are informed by feedback from multi-agency meetings and minutes from multi-agency meetings are retained in the child's record.

3.15 Effective processes are in place in CAMHs to ensure that children and young people who are engaged with the service are well safeguarded. Identification of risk by practitioners in CAMHs is good, and facilitated by a clear alert system which flags risks on CAMHs records. Risk assessments are being regularly updated within expected timescales, and risk assessments and care plans are reviewed by managers on a weekly basis. This oversight and scrutiny ensures that CAMHs practitioners have appropriately identified and responded to all the risks associated with the children and young people that they are supporting

3.16 Children who are identified as being at risk of Child Sexual Exploitation (CSE) are referred to the multi-agency CSE hub where a health practitioner (funded by Leicestershire Police) effectively facilitates information sharing across health partners. CSE Hub triage meetings are held on a daily basis to discuss all new cases. This ensures that referrals are responded to as soon as practicable. Weekly hub meetings also provide an effective forum to discuss the most complex and high-risk cases with key partners to ensure a collaborative and multi-agency response.

3.17 Currently, the majority of the referrals received by the multi-agency hub are for young people aged 15-17 years. Approximately one third of those young people referred have not previously engaged with any other services. During this inspection, we found that in some health services, such as in ED, school nursing and midwifery, that the use of a CSE screening tool was inconsistent, and therefore the likelihood of identifying CSE at the earliest opportunity is reduced. *This has also been brought to the attention of Public Health.* (**Recommendations 1.6, 2.12 and 4.4**)

3.18 Effective arrangements are in place in the Contraception and Sexual Health (CASH) service to identify and protect children who are at risk of CSE. Children's social care provide the CASH service with a monthly list of all the children and young people who have been identified as being at risk of CSE across Leicestershire. This information is added to their electronic system, and flags are put in place to ensure that if a child or young person presents at the CASH service that staff are able to immediately provide interventions that further safeguard and support the service user.

3.19 Practitioners in the CASH service are professionally curious and are effectively exploring the risks associated with presenting children and young people. In records examined, we saw evidence of contact with children's social care and referrals being made to a variety of different agencies to ensure that children and young people were effectively supported and safeguarded.

3.20 Whilst practitioners in CASH are making referrals to children's social care, outcomes of referrals are not always being fed back to the practitioner making the referral. Some practitioners told us that been occasions when then they believed that their referrals had been accepted and that young people had support in place, but when the young person re-presented at the CASH service, it was apparent that their risks had not been addressed. Ensuring the outcomes of referrals are communicated and understood is a shared responsibility of children's social care and the referrer. *This has also been brought to the attention of Public Health. (Recommendation 3.1)*

3.21 The "Spotting the Signs" tool kit is built in to the CASH service electronic record keeping system. This alerts staff to complete an additional risk assessment for any young person who presents at the service and who is under 16 years of age. New risk assessments are completed every time a child or young person attends the service, and this has assisted practitioners in identifying if risks are diminishing or escalating. When levels of risk escalate, practitioners are pro-active in liaising and engaging other agencies to ensure that the young person is protected from further abuse and harm.

3.22 Children and young people who live in households where it has been identified that there is a risk of domestic violence are safeguarded effectively in Leicestershire. The adult mental health team have strengthened networks with partner agencies and the Trust's safeguarding leads regularly attend MARAC and MAPPA meetings. Information from these meetings is shared at the adult mental health monthly safeguarding meeting which ensures that practitioners are fully briefed of risks are associated with their clients. We saw evidence of practitioners giving good consideration of how identified risks may impact on children associated with service users. In one case examined, the service user had links to numerous children and the practitioner was well involved in child protection processes and effective multi-agency liaison.

3.23 Formal information sharing arrangements between Turning Point, the integrated young person and adult substance misuse service, and health and social care is yet to be adopted despite an agreement being in draft for a considerable period. We know that gaps and delays in information sharing is often a key finding in serious case reviews.

3.24 The majority of GPs across Leicestershire use the same electronic patient record system, which facilitates effective information sharing. Alerts are in place to support primary care practices in recognising children and families who have safeguarding concerns. In both practices that we visited, further work was required to ensure that data is regularly cleansed and that data recorded on the patient record system is relevant and up to date regarding the status of vulnerable children. In one of the practices we visited, one 35-year-old adult was recorded as a looked after child. **(Recommendation 4.6)**

3.25 Whilst safeguarding practices in both of the GP practices that we visited were well embedded, professional curiosity of GP's was too variable. In one of the cases reviewed, a locum GP had examined a pregnant 16-year-old who had attended for a check-up. It was not obvious from the GP's notes if the GP had explored if the young person was safe and well, and if the pregnancy resulted from an age-appropriate and consensual relationship. (**Recommendation 4.7**)

3.26 Both of the GP practices that we visited hold regular safeguarding meetings where the most vulnerable children and families are discussed. In addition to these meetings 'daily huddle' meetings are held where staff and clinicians can flag any concerns that they have about patients that they saw the previous day. The safeguarding leads from both practices are also attending GP forums where any learning is disseminated and used to improve safeguarding practice within their practices.

4. Looked after children

4.1 Some Looked after Children (LAC) are waiting too long for medical examinations when they enter the care system. The timeliness and performance data for initial and review health assessments for Looked after Children in Leicestershire is relatively poor compared to neighbouring local areas and national average performance indicators. Notifications from the local authority are not always being promptly received by the LAC health team when a child has been brought into care. This is resulting in unnecessary delays to health needs, vulnerabilities and needs of looked after children being addressed and met. (**Recommendation 1.7 and 4.15**)

4.2 Delays in assessment and care planning for children looked after have resulted from reduced capacity within the LAC health workforce. Leicestershire has experienced significantly more requests to complete assessments for looked after children than they can effectively manage. There is a recovery plan in place to address the identified issues of capacity and availability, however this plan has yet to sustainably improve performance. It is recognised that improvements in outcomes are also dependent on progress being made to address the wider issues across partnership agencies outlined in the Health Needs Assessment (HNA) which was recently completed by Public Health. (**Recommendation 1.6 and 4.8**)

4.3 Additional clinics have been put in place in an attempt to offer earlier and more timely appointments for medicals to ensure that looked after children have their health needs and inequalities met. However, due to capacity issues within the LAC health team, there is limited opportunity for health assessments to be carried out other than in clinics, which means that some children in the care system are having to miss school or travel. This can be challenging for some children and carers who live in the more isolated and rural parts of the county. (**Recommendation 1.8 and 4.16**)

4.4 Improvements in arrangements and partnership working means that looked after children are having their emotional and mental health needs addressed more effectively. The local area has recognised in its refreshed Joint Needs Health Assessment (JSNA), the need to prioritise the mental health and well-being of children in the care system, and the need to improve timely access to mental health provision. The new CAMHs contract, which was implemented in April 2018, has led to better outcomes for children who are looked after, as they are now able to receive enhanced levels of support and are not subject to lengthy waits for assessment and intervention.

4.5 The LAC health team have a tenacious and diligent approach in tracking and following up looked after children who do not attend their health appointments. The role of the care navigator is effective in tracking children's attendance and non-attendance, and in alerting the wider health team to children who are not attending appointments or who are refusing to engage with the LAC service. These arrangements are improving the LAC health team's vigilance of children who are not receiving support and who are therefore at risk of not having their health and wellbeing needs met and appropriately safeguarded.

4.6 The voices, needs and experiences of children who are looked after are not fully understood by the LAC health team. Whilst some surveys have been carried out to capture the views of children and young people, findings have not yet been fully collated and analysed. Therefore, the local area has more work to do to learn from the voices of service users and to ensure that their views are given appropriate priority when considering service design and improvements. (**Recommendation 1.9 and 4.17**)

4.7 Foster carers are well supported by the LAC health team who recognise that good levels of support, training and advice support the sustainability and permanence of placements. A good range of training is being provided to foster carers on subjects such as behaviour management, the development of speech and language and the impact of abuse and neglect on children's health and wellbeing. Improved networks of support for foster carers is helping to equip them with enhanced knowledge and skills which they can use to support the child or young person in their care.

4.8 There is a 'strategy call' system in place which ensures that health advice is provided by the LAC duty team 4 days per week in response to concerns about the health, development and safety of a looked after child, or when there are concerns about a placement breakdown. This system is well used, and the number of strategy calls for advice are increasing. However, no work has yet been undertaken to analyse trends and dynamically inform changes to service delivery or placement planning. The implementation of the strategy call system is a beneficial and priority piece of work which is being carried out at a time when the capacity of the current LAC service is significantly challenged. Therefore, there the sustainability of this system may be a challenge and an area of risk.

4.9 Learning from two recent incidents have highlighted that joint working and information sharing between the LAC health team, paediatricians and other community health professionals is not always effective and robust. Whilst it has also been identified that allied health professionals such as school nurses, required require additional training to improve their understanding of their responsibilities and standards of practice in supporting looked after children, capacity within the LAC health team means that this training is yet to be delivered. (**Recommendation 1.10 and 4.18**)

4.10 Effective liaison between the LAC health and Local Authority administration teams provided effective scrutiny and monitoring of children in care who move across the different localities of Leicester, Leicestershire and Rutland. Weekly data checks are robust in ensuring that children's legal status is accurate, and that information regarding their circumstances is current.

4.11 The identification of risks to looked after children in Leicestershire is good. There is a robust flagging system on LAC health records which highlight when children and young people are vulnerable to CSE. The LAC health team are also effectively exploring the risks and vulnerabilities of unaccompanied children who are seeking asylum.

Child C, a 17 year old unaccompanied male, had been trafficked into the UK from his own country. As part of the initial health assessment, the clinician completing the assessment sensitively explored the traumas and adverse childhood experiences that the young person had experienced.

An interpreter was appropriately used to support engagement, effective communication and understanding.

The quality of the assessment was good, and provided a holistic and detailed picture of the young person. The actions that needed to be undertaken to meet the identified needs and to mitigate any potential risk to the young person were clearly identified.

5. Management

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

5.1 Leadership and management

5.1.1 Partnership working across Leicestershire is effective. Practitioners across health and non-health disciplines are effectively sharing information and risks in a timely way. This is improving outcomes for children and young people by ensuring that additional help and support is put in place which appropriately meets identified needs and safeguards vulnerable children, young people and families

5.1.2 Effective and well-embedded partnership working with the CCG and LSCB ensures that health remains an integral part of Leicestershire's safeguarding agenda. There is consistent health representation at the LSCB and board members are open to challenge from their peers to ensure that the needs of vulnerable children and families remain a priority.

5.1.3 Management oversight has been strengthened by ensuring that the workforce has access to adequate and effective IT systems which support the timely and safe sharing of confidential and sensitive information. The multiplicity of systems has been reduced, and the majority of community health services now have access to SystemOne, which has helped to reduce gaps in information and improved the co-ordination and multi-agency response to risk.

5.1.4 Senior leaders in the CCG and the local authority are not sufficiently well-informed about progress, risks and trends in shared work to improve the outcomes of looked after children. The CCG has not received an annual report which reviews the effectiveness of local health arrangements in meeting the needs of children who are looked after or care leavers. Whilst a health needs assessment of the needs of looked after children has recently been carried out by public health, there is no joint action plan in place to ensure that clear actions are being carried out to improve the health outcomes for children looked after. (**Recommendation 1.11 and 4.9**)

5.1.5 The health leadership arrangements for looked after children in Leicestershire are not compliant with intercollegiate guidance which indicates the need for designated and named roles to be held by separate post holders to avoid potential conflicts of interest. The designated doctor is also fulfilling the named doctor role for looked after children. This dual responsibility can lead to a conflict of interest, with the post holder having responsibility for strategic and operational delivery of the service. Similarly, the designated nurse who is employed by the provider NHS Trust LPT, is also carrying out some of the named nurse role and responsibilities. We heard that the CCG recognise the challenges and limitations of these current arrangements, and discussions have been had to prepare a formal transfer of the designated nurse post into the CCG. As an interim measure, the designated/named nurse has been placed some of the time within the commissioning function to better represent and drive forward the needs of the LAC population. However, these arrangements are yet to be formalised by the CCG and there are no plans in place to amend service structure to reduce potential conflict which may arise from the dual doctor role. (**Recommendation 4.8**)

5.1.6 Key strategic developments within the LAC health service have not been implemented in a timely way due to the capacity and resourcing issues within the service. This means that children and young people are not yet benefitting from an improved LAC service. The CCG have drafted a new service specification which aims to strengthen the focus on performance and outcomes. Implementation of the new service specification has been postponed until April 2019 as there has been reduced opportunities for the designated nurse to meet with the designated doctor to drive forward shared approaches to service improvement.

5.1.7 The continuity of care and support for looked after children and those children placed of area is too variable. The availability and capacity of LAC health nurses within LPT is an area of concern, as staffing levels have been adversely affected by high levels of sickness absence and the lack of full time practitioners. One young person that was a looked after child told us “I wish I could see my LAC nurse more, as whenever I see my nurse it is good and she really helps me.” This capacity issue has also impacted on the opportunity to implement new models of support which would provide greater managerial oversight of children who are placed out of the county. (**Recommendation 1.12 and 4.19**)

5.1.8 Co-operative working between health and children’s social care has recently been strengthened. We heard that there is an open culture of professional challenge, and whilst there is a formal escalation policy in place to resolve cases of professional disagreement, the number of instances where this has been invoked has reduced. This is due to most issues being resolved at an operational level and is indicative of good professional relationships and mutual respect.

5.1.9 The named GP role is well embedded, and the named GP has been instrumental in promoting child protection and safeguarding across Leicestershire. Improvement in safeguarding practice across primary care has been a priority for the local area, and the named GP has been well supported by designated professionals in effectively promoting and implementing effective safeguarding practice. As a result, we have seen good commitment by GP’s in recognising their role in protecting and safeguarding children and young people.

5.1.10 GPs across Leicestershire are well engaged in developing their understanding and ability to recognise domestic violence. This has been supported by an effective domestic violence policy and programme of training which has been co-produced with designated professionals, the named GP and frontline GPs. This policy has helped GP practices to provide a consistent and appropriate response to those families where domestic violence is a factor.

5.1.11 Whilst the named GP informed us that they are well supported by the CCG and designated professionals, we were told that their capacity to oversee and promote effective safeguarding practice across primary care is limited due to a lack of capacity. The named GP is providing less sessions to fulfil the role as is set out by the Assurance and Accountability Framework which strongly recommends that named GPs provide a minimum of 2 sessions per 220,000 population. (**Recommendation 4.10**)

5.2 Governance

5.2.1 Whilst there are appropriate governance arrangements in place across the health economy, senior leaders across the CCG and Trust boards cannot be assured of the quality of safeguarding practice at an operational level. This is due to a lack of audit across both NHS trusts which would provide an insight into the effectiveness of current safeguarding practice and arrangements in Leicestershire, and help provide a clearer picture to commissioners who could use the key findings of audits to influence future service design and delivery. (**Recommendation 1.17, 2.13 and 4.11**)

5.2.2 Regular multi-agency audits and deep-dives into cases are carried out by the LSCB are identifying areas of good practice and development in safeguarding arrangements across the county. However, there is an over-reliance from health on these audits as we saw little evidence of safeguarding audits being carried out across both LPT and UHL. (**Recommendation 1.17, 2.13 and 4.11**)

5.2.3 Work is underway to ensure that the transition from the current Local Safeguarding Children's Board (LSCB) arrangements to the new Local Safeguarding Children's Partnership (LSCP) as required by amendments to the Children and Social Work Act 2007 and Working Together 2018 enables a consistent and robust response to safeguarding. All members and key partners have been involved in consultations and the Collaborative Commissioning board has good oversight of the progress that is being made to establish and effective LSCP by September 2019.

5.2.4 Designated and named professionals meet at monthly operational meetings and bi monthly business meetings to agree on shared safeguarding priorities, actions and governance arrangements. The CCG's safeguarding work plan is the main agenda item of this meeting and discussing the agreed work plan regularly ensures that senior leaders are aware of their collective and individual responsibilities in driving forward and implementing improvements which will result in more effective and robust safeguarding arrangements in Leicestershire.

5.2.5 The arrangements for sharing and recording patient information in ED are not effective. Record keeping is fragmented and cumbersome as current systems do not promote easy and effective communication. Health information is recorded on paper records and two different systems are being used to record safeguarding incidents. The use of paper records and the multiplicity of systems, increases the likelihood of incomplete record keeping. Staff that we spoke with told us that current systems and arrangements makes information sharing time consuming. (**Recommendation 2.8**)

5.2.6 Managers of health visiting teams are carrying out regular scrutiny of health visiting records and therefore have a good oversight of the quality and effectiveness of record keeping. Dip samples of records are sampled monthly, and the findings from case sampling are fed back to individual and at team meetings to help promote a consistently high level of safeguarding practice.

5.2.7 There is a strong emphasis on audit in CAMHs, which is contributing to steady improvements being made to services for vulnerable children and young people with mental health needs. Audits have highlighted to the CCG that there is a growing number of children and young people across Leicestershire admitted into in-patient specialist CAMHs units and that ADHD and Autism is a factor that underpins a significant number of admissions. Work to address this issue and to develop appropriate care pathways continue to feature in the local area's planning as part of Futures in Mind and local transformation plans. The CCG acknowledge that transition planning between CAMHs and adult mental health services for those young people with neuro-developmental conditions is an area which needs to be further developed.

5.2.8 Continual audit programmes in CAMHs has provided managers with and increased understanding and oversight of how implemented service models are working more cohesively to bring about positive and sustainable improvements. Whilst there still remain considerable improvements that need to be embedded, the service transformation is beginning to result in improved outcomes for children and young people.

5.2.9 A continuous programme of audit is being carried out in Adult Mental health. Audits focusing on a number of key topics have been conducted which include CSE, the quality of referrals made to children's social care, and neglect. Whilst the findings from audits have helped to improve safeguarding practice and to embed a "Think Family" approach, there is no audit in place to ensure that children's demographics and safeguarding alerts are being appropriately recorded and used on the electronic patient record. This is a missed opportunity to ensure that children who are linked to service users are easily and immediately identifiable on all adult mental health records. (**Recommendation 1.13**)

5.2.10 Primary care compliance with arrangements to safeguard children, young people and vulnerable families has been further strengthened due to all GP practices being issued with a self-assessment on safeguarding quality markers. This self-assessment tool has been recently updated to include learning and recommendations from serious case reviews (SCRs) and domestic homicide reviews (DHRs) and helps to benchmark and improve safeguarding activities within general practice. The named GP has been supporting GPs across Leicestershire to complete the self-assessment and returns are due by the end of 2018.

5.2.11 Despite there being a nationally agreed pathway in place to support those children who are at risk of county lines exploitation, and recognition by the local area that a significant number of children in Leicestershire may be at enhanced levels of risk, there has been little done to date to ensure that a pathway of care is commissioned in Leicestershire. (**Recommendation 4.13**)

5.3 Training and supervision

5.3.1 A significant number of health practitioners in Leicestershire are receiving safeguarding training which is not fully compliant with intercollegiate guidance. Whilst we saw evidence of safeguarding featuring regularly in training, often safeguarding training being provided is single agency, and the opportunity to reflect and discuss safeguarding in a multi-agency setting which contributes to improvement in front line practice is lost. *This has been brought to the attention of Public Health.* (**Recommendation 4.12**)

5.3.2 Clinicians and staff in paediatric ED are provided with regular opportunities to share learning and continually develop their safeguarding skills and practice. A senior nurse holds monthly safeguarding training sessions and operational and liaison meetings all feature safeguarding as a standing agenda item, which is ensuring that practitioners are kept up to date with any changes in safeguarding practice and policy.

5.3.3 Good progress has been made by both LPT and UHL to ensure that staff and clinicians have received training in PREVENT. This means that more staff in the acute and community sectors have been trained to recognise and support those children, young people who may be at risk of radicalisation or extremism. However, neither of the two GP practices that we visited had received any PREVENT training and were not aware of the local arrangements for PREVENT. (**Recommendation 4.14**)

5.3.4 The training provided to GPs by the named GP has been fully evaluated. This has helped the named GP to identify gaps in knowledge and expertise which may impact on GP's ability to robustly safeguard children and vulnerable families. The named GP has been nominated for the NSPCC Safeguarding Trainer of the Year Award 2019 in recognition of the impact that the training provided has had in promoting effective safeguarding practice across Leicestershire.

5.3.5 Whilst the health practitioner in the CSE hub is not funded by health, they have good access to training and supervision which is provided by the LPT safeguarding team. This ensures that the practitioner is well aware of changes to safeguarding practice and policy, and is also well supported in managing multiple complex and high-risk cases.

5.3.6 The midwives that we spoke with told us that they are not receiving regular safeguarding supervision. Regular one to one supervisions which enable midwives to reflect and be supported in analysing risk are not routinely provided due to capacity within midwifery teams. When supervision does take place, a record of the key points that were discussed and any actions arising from supervision is not consistently recorded and referenced in the patient record. (**Recommendation 2.9**)

5.3.7 Safeguarding midwives are also not receiving supervision to enable them to continually develop their learning and improve their practice. Effective supervision is important for named safeguarding midwives so they can disseminate best practice and guidance to the wider workforce. Whilst the UHL have begun to introduce standardised supervision for practitioners who work with children, initial uptake has been poor and it is too early to be able to access the impact of the new supervision processes.

5.3.8 Safeguarding supervision for health visitors is inconsistent. Health visitors are not regularly in receipt of safeguarding supervision and only receive one to one support if they request it. The current model does not provide sufficient assurance that practitioners are being provided with regular opportunities to reflect on their practice and to receive regular support in the management of complex cases. *This has been brought to the attention of Public Health.* (**Recommendation 1.14**)

5.3.9 In school nursing the propensity for cases to drift and for risks and vulnerabilities to remain unidentified is increased by the lack regular one to one supervision. Whilst school nurses are required to participate in mandatory group supervision, one to one supervision are not mandatory and are only provided at the request of the individual school nurse. *This has been brought to the attention of Public Health.* (**Recommendation 1.14**)

5.3.10 The supervision model offered by Tuning Point is effective. Practitioners are provided with regular one to one management supervision during which safeguarding is discussed, and bi-monthly action learning sets which ensure that practitioners are continually enhance their knowledge on key safeguarding themes. Outcomes from supervision were consistently recorded in the client records we examined, and the learning action sets had improved practitioner's knowledge and skills of how to seek support from other partner agencies to support their work with complex clients.

Recommendations

1. **Leicestershire Partnership Health Care NHS Trust in partnership with Public Health should:**
 - 1.1 Ensure that the capacity of the school nursing service meets demand, and that steps are taken to ensure that service delivery is as equitable as possible. Steps should be taken to avoid delays in identifying risks and meeting vulnerable children's and family's needs.
 - 1.2 Improve quality assurance processes to ensure that front line practitioners are consistently being professionally curious and are effectively identifying additional needs and vulnerabilities at the earliest opportunity.
 - 1.3 Continue to review and reduce the multiplicity of care pathways in the Core CAMHs.
 - 1.4 Ensure that effective and proactive monitoring of children and young people who are awaiting treatment for mental health conditions is in place to avoid unnecessary drift and delay.
 - 1.5 Support practitioners in their understanding of complex family compositions and arrangements by promoting the use of chronologies and genograms in their case work.
 - 1.6 Ensure that screening tools are effectively and consistently used to support practitioners in the identification of CSE, and that where concerns have been identified they are shared with relevant health partners and children's social care so that an appropriate and co-ordinated response can be put in place.
 - 1.7 Strengthen communication and arrangements with the local authority to ensure that notifications made when a child becomes looked after are received in a timely way and that delays in conducting health assessments are minimised.
 - 1.8 Review the arrangements in the LAC health service to ensure that those looked after children who are hard to reach or difficult to engage can access health appointments in a variety of settings which best meet their needs.

- 1.9 Ensure the voice of the child is kept at the centre of looked after children health assessments and care plans and that changes in service design are effectively co-produced with children who are looked after, with adequate consideration being given to their experiences and opinions.
- 1.10 Strengthen effective information sharing between the LAC health team, paediatricians and relevant community health practitioners to provide a full picture of what is known about the lived experiences of children and risks to their health, development and safety.
- 1.11 Provide a detailed annual audit and annual report of LAC performance to the CCG to ensure that they are well sighted on gaps in service delivery.
- 1.12 Review the capacity shortfalls within the LAC health service and ensure children placed in care placements within and outside of Leicestershire benefit from comprehensive assessments and health care plans, including recognition of their emotional and mental health needs and of actions being taken to safeguard them.
- 1.13 Review how children's demographic information is recorded on adult mental health records to ensure that children associated with adult service users are immediately identifiable on electronic patient record systems.
- 1.14 Ensure that health visitors and school nurses are provided with mandatory and regular one to one supervisions where complex cases can be discussed, and the practitioners practice and decision making can be challenged and further developed.
- 1.15 Assure themselves that the local arrangements to share ED attendances with health visitors and school nurses are appropriately identifying existing and emerging risk and that thresholds for sharing attendances are appropriate.
- 1.16 Review the capacity of both the designated LAC and safeguarding professionals to address gaps in strategic capacity and ensure the sustainability of local arrangements to drive forward significant continuous improvement and transformation.
- 1.17 Ensure that effective, regular safeguarding audits are being carried out to provide greater assurance of the effectiveness of safeguarding practice at an operational level.

2. University Hospitals of Leicester NHS Trust should:

- 2.1 Continue to ensure that they are making proactive steps to recruit clinicians and staff that have the adequate paediatric skills and competencies required to support and safeguard children and young people.
- 2.2 Ensure that clinicians are aware of the impact that alcohol and substance misuse had on children's health and safety, and are routinely making referrals to Turning Point to enable children and young people who have been admitted due to alcohol or substance misuse receive ongoing support post discharge to address their needs.
- 2.3 Provide clinicians with an effective screening tool to facilitate the identification of vulnerabilities and needs of adolescents and young adults.
- 2.4 Ensure that clinicians make effective use of electronic patient record systems and are provided with an effective screening tool to facilitate the identification of children associated with adults.
- 2.5 Continue to drive forward the implementation of the CP-IS system to further support the identification of safeguarding risks and vulnerabilities.
- 2.6 Seek assurances that patient records systems enable all midwives to access vital safeguarding information out of hours in the absence of safeguarding midwives so that they are able to keep vulnerable women and their babies safe.
- 2.7 Ensure that hospital and community midwives are routinely sharing safeguarding concerns directly with children's social care without unnecessary delay to ensure that needs and vulnerabilities are responded to as swiftly as practicable.
- 2.8 Ensure that record keeping systems in place across UHL supports staff and clinicians to easily and share information in a timely way, and review current systems to ensure that they facilitate effective record keeping.
- 2.9 Support midwives by implementing an effective supervision model which provided all midwives including safeguarding midwives with regular one to one supervision.
- 2.10 Assure themselves that appropriate arrangements to share ED attendances with health visitors and school nurses are in place and that thresholds for sharing attendances are appropriate and facilitate the identification of emerging risk.

- 2.11 Support practitioners in their understanding of complex family compositions and arrangements by promoting the use of chronologies and genograms where appropriate.
- 2.12 Ensure that screening tools are effectively and consistently used to support clinicians in the identification of CSE, and that where concerns have been identified they are shared with relevant health partners and children's social care to enable a co-ordinated response to be put in place.
- 2.13 Ensure that effective, regular safeguarding audits are being carried out to provide greater assurance of the effectiveness of safeguarding practice at an operational level.

3. Midlands Partnership NHS Foundation Trust should:

- 3.1 In the CASH service ensure an effective system of quality assurance of all referrals to children's social care. This should promote wider understanding of factors that lead to escalation and tracking of the impact of safeguarding work undertaken and review of the outcomes for the child/children.

4. Leicester CCG, West Leicestershire CCG together with East Leicestershire and Rutland CCG should:

- 4.1 Work with UHL and LPT to gain assurance that interdisciplinary communication is embedded in practice, and that robust and timely information sharing between the acute and community sectors is supported by appropriate governance arrangements.
- 4.2 Work with Public Health to support LPT in addressing capacity issues within the school nursing team to ensure that the service offer is equitable and consistently meeting the needs of the school age population in Leicestershire.
- 4.3 Ensure that GPs are well involved in child in need processes and are providing a comprehensive picture of children who are living in situations where their basic needs and additional vulnerabilities may not be met.
- 4.4 Ensure that screening tools are effectively and consistently used by all health services to support practitioners in the identification of CSE, and that where concerns have been identified they are shared with relevant health partners and children's social care so that an appropriate and co-ordinated response to risk can be put in place.

- 4.5 Work with Public Health, Turning Point and Social Care Partners to develop and embed an appropriate information sharing agreement between Turning Point and health and social care partners to ensure that all relevant agencies are aware of risks to children and young people that may arise from associated adult's substance misuse.
- 4.6 Work with local primary care services to implement the nationally agreed read codes are appropriately maintained and kept up to date to reflect changes in children's legal status or care arrangements.
- 4.7 Work with primary care services to undertake further work to further embed the 'Think Family' agenda across primary care, to encourage professional curiosity and to ensure that locum GPs are well aware of local arrangements to safeguard children and young people.
- 4.8 Review the capacity of both the designated LAC and safeguarding professionals to address gaps in strategic capacity and ensure the sustainability of local arrangements to drive forward significant continuous improvement and transformation.
- 4.9 Ensure that a LAC annual report is received from LPT and utilise the performance data and qualitative information provided to shape and improve service design and delivery.
- 4.10 Review the current capacity of the named GP and ensure that named GP post holders have sufficient capacity to continue to drive forward the children's safeguarding agenda across primary care.
- 4.11 Ensure that effective safeguarding audits are being carried out by both NHS Trusts to provide greater assurance of the effectiveness of safeguarding practice at an operational level.
- 4.12 Work with provider organisations to review current programmes of safeguarding training to ensure that health practitioners are provided with training which is multi-agency and compliant with current intercollegiate guidelines.
- 4.13 Consider implementing a pathway to provide effective support to those children and young people who are at risk of county lines exploitation.
- 4.14 Ensure that GPs are receiving required PREVENT training to support them to identify and safeguard young people who may be vulnerable to radicalisation.
- 4.15 Work closely with, and provide support to LPT to ensure that effective arrangements are in place to ensure that children who are looked after receiving their looked after health assessments in accordance with statutory timescales.

- 4.16 Work with the LAC health service to ensure that those looked after children who are hard to reach or difficult to engage can access health appointments in a variety of settings which best meet their needs.
- 4.17 Support the LAC health service to ensure that changes in service design are effectively co-produced with children who are looked after, with adequate consideration being given to their experiences and opinions.
- 4.18 Work with the LAC health team to ensure that information sharing between the LAC health team, paediatricians and relevant community health practitioners is effective and helping to provide a picture of what is known about the lived experiences of children and risks to their health, development and safety.
- 4.19 Review the capacity shortfalls within the LAC health service and ensure children placed in care placements within and outside of Leicestershire benefit from comprehensive assessments and health care plans, including recognition of their emotional and mental health needs and of actions being taken to safeguard them.

5. Turning Point should:

- 5.1 Continue to ensure that clinicians in ED are provided with regular up to date information and briefings about the Turning Point service so they are aware of the support that Turning Point can offer children and young people who are admitted through alcohol and substance misuse. Regular updates and briefings should continue to be provided to enhance clinicians' knowledge and understanding of signs, symptoms and the implications of substance misuse in young people. The low referral rates from ED should be explored and current referral pathways should be explored to evaluate their effectiveness.

Next steps

An action plan addressing the recommendations above is required from West Leicestershire CCG and East Leicestershire and Rutland 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.