

# **Review of health services for Children Looked After and Safeguarding in Sandwell Metropolitan Borough**

# Children Looked After and Safeguarding

## The role of health services in Sandwell Metropolitan Borough

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<b>Provider services included:</b>	Sandwell & West Birmingham Hospital Trust. Birmingham Community Healthcare Trust Brooke Advisory Service IRIS, Integrating Recovery in Service (Cranstoun, adult substance misuse service) Black Country Partnership NHS Foundation Trust
<b>CCGs included:</b>	Sandwell and West Birmingham Clinical Commissioning Group
<b>NHS England area:</b>	Birmingham, Solihull and The Black Country
<b>CQC region:</b>	Central
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## Summary of the review

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

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

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## About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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

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

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

In total, we took into account the experiences of 58 children and young people.

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## Context of the review

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*There are 110 GP Practices within Sandwell and West Birmingham CCG.*

*At the end of March 2013, 26.8% of the population of Sandwell was under the age of twenty, with 45.3% of school children from a black or minority ethnic group. Figures from the 2011 census recorded that 30.6% of Sandwell's children are living in poverty compared to 23.8% of the West Midlands and 21.1% in England. The rate of family homelessness is worse than the England average (3.7 in Sandwell compared to 1.7 in England).*

*The health and well-being of children in Sandwell is generally worse than the England average. Children in Sandwell have worse than average levels of obesity. 11.2% of children aged 4-5 years and 25.7% of children aged 10-11 years are classified as obese.*

*Only 44.8% of children participate in at least three hours of sport a week which is lower than the England average. However a higher percentage of children in care are up-to-date with their immunisations and GCSE achievement is similar to the England average for this group of children. The overall percentage of all Sandwell's children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly worse when compared to the England average.*

*The infant mortality rate in Sandwell is significantly worse (6.7 per 10,000 in Sandwell compared to 4.4 in England) and the child mortality rate is comparable to the England average. The 2012/13 annual Child Death Overview Panel report notes that in 2012/13 there were a total of 55 child deaths of which eight were unexpected. Although the total number of reported deaths in 2012/13 has increased since previous years there was no increase in the number of unexpected deaths. Twenty-eight child deaths were reviewed in the year, and of these, three were identified as having modifiable factors. In none of these cases was a serious case review (SCR) deemed necessary. In April 2013 Child C, who died at home in 2011, was subject to an SCR commissioned jointly by Dudley LSCB and Sandwell LSCB.*

*The indicator for the rate of A&E attendances for children under four years of age in 2011/12 was significantly worse than the England average. In terms of hospital admissions, the rate of hospital admissions caused by injuries in children under 14 years of age was significantly worse when compared to the England average. The rate of hospital admissions caused by injuries in children and young people between the age of 15 and 24 years was comparable to the England average.*

*With regards to mental health in 2012/13, the rate of hospital admissions for mental health conditions and the rate of hospital admissions as a result of self-harm was significantly worse when compared against the England average.*

*In 2011, the conception rate for under 18 year olds per 1000 females in Sandwell and the percentage of teenage mothers in 2012/13 was observed to be significantly worse than the English average. Both breastfeeding indicators (breastfeeding initiation and breast feeding prevalence at 6-8 weeks after birth) were also worse than average.*

*Information supplied by the children's social care data and performance team at Sandwell Metropolitan Borough Council shows that at the end of February 2014 the rate of children subject to child protection per 10,000 of the 0-18 population was 51.9 which is above the 2013 national average but lower than the average of statistical neighbours. There are 77 children per 10,000 in Sandwell who are looked after compared to 59 in England.*

*There were 607 children and young people looked after by Sandwell Metropolitan Borough Council on the 31<sup>st</sup> January 2014, of these 272 were placed within the Borough of Sandwell and 331 were placed outside the borough. As of February 2014, Sandwell and West Birmingham Clinical Commissioning Group (CCG) have financial commitments for 36 children and young people in external therapeutic placement, specialist education provision or accessing specialist foster care for identified medical needs.*

*A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Sandwell. The average score per child in 2013 was 13.6. Despite Sandwell's average being lower than the English average score of 14.0, Sandwell's score is considered to be borderline cause for concern. Sandwell's average score over the last two years has generally remained consistent.*

*In 2013, the DfE reported that Sandwell had 430 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). The DfE reported that 91.9% of these children received their annual health assessment and 91.9% of LAC had their teeth checked by a dentist. Both of these metrics are higher than the England average. As at 31 March 2013, there were 110 looked after children who were aged five or younger, of these children 63.6% had up to date development assessments*

*An audit of the health needs of Sandwell looked after children were identified at the initial health assessment for the period April 2013-February 2014:*

*There were 176 children and young people seen by the designated doctor for looked after children, of these only 34 had no health concerns or issues requiring referral. One hundred and forty-two had a range of issues with four having six or more identified health issues. There were a total of 341 issues requiring actions that were affecting the health and well-being of children on entering care. There were 63 children and young people referred to dental services for a formal assessment with 20 requiring additional treatment. Fifty-one children and young people were referred to optician and ophthalmology services for a formal assessment, of these nine required assessment of a squint and 15 required review or replacement of glasses. Thirty-two children and young people were identified to be delayed in their immunisation programme. Twenty-one had emotional or mental health concerns and 35 were referred for educational assessment or support.*

*Commissioning and planning of most health services for children are carried out by Sandwell & West Birmingham Clinical Commissioning Group (CCG).*

*Commissioning arrangements for looked-after children's health are the responsibility of Sandwell & West Birmingham CCG and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by Sandwell & West Birmingham CCG Safeguarding Children Unit.*

*Acute hospital and health visiting services are provided by Sandwell & West Birmingham Hospital Trust.*

*School nurse services are commissioned by Public Health, Sandwell Metropolitan Borough Council and provided by Birmingham Community Healthcare Trust.*

*Contraception and sexual health services (CASH) are commissioned by Public Health, Sandwell Metropolitan Borough Council and provided by Brooke Advisory Service and Sandwell & West Birmingham Hospital Trust.*

*Child substance misuse services are commissioned by and provided by Public Health, Sandwell Metropolitan Borough Council and provided by DECCA (not visited in this review).*

*Adult substance misuse services are commissioned by Public Health, Sandwell Metropolitan Borough Council and provided by Cranstoun (IRIS, Integrating Recovery in Service).*

*Adult mental health and Child and Adolescent Mental Health Services (CAMHS) are provided by Black Country Partnership NHS Foundation Trust. The specialist CAMHS service also runs the deliberate self-harm service. This service caters for children and young people (aged up to 16 or 16 to 18 if in full-time education) who enter Sandwell Hospital's Paediatric Unit showing signs of deliberate self-harm.*

*There is no Sexual Assault Referral Centre (SARC) for children in the West Midlands; in Sandwell, children under 16 are seen in the NHS paediatric outpatient clinic, which isn't forensically secure nor suitable for these situations. Sandwell safeguarding children's board (SSCB) has supported proposals to develop a children's SARC, but to date, this has not been provided by the NHS. The SSCB reports that the Director of Public Health is reviewing the situation.*

*From August 2014, a Black Country rota for children presenting out of working hours with an allegation of child sexual assault has been in place. If a medical assessment is required urgently, Sandwell cases are seen within this system at New Cross Hospital, which has a forensically secure suite (historical cases and cases in working hours continue to be seen at Sandwell Hospital).*

*In the past year the CQC have not received any child concerns or child alert enquiries for any of the health provider locations within Sandwell.*

*The last inspection of health services for Sandwell's children took place in November and December 2009 (published in February 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services (SLAC). The overall effectiveness of the safeguarding services in Sandwell was assessed at that time as inadequate. Capacity for improvement was assessed as inadequate. Overall effectiveness of services for looked after children and young people in Sandwell was assessed as adequate. Capacity for improvement was assessed as adequate. At the time of the SLAC inspection, no separate judgements were made for health's contribution to safeguarding or for the delivery of health support to looked-after children. Recommendations from that inspection are covered in this review through the key lines of enquiry.*

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## The report

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

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## What people told us

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### **We heard from a young person who is supported by the child and adolescent mental health service;**

*"CAMHS have really helped me. The support has been immense. My CAMHS worker gets it and really empathises with what I'm going through. She comes to my CLA review and speaks up for me when I can't. I'm clean from self-harming and without their support, this wouldn't have been possible."*

### **We spoke with an expectant Sandwell mother at the maternity unit in Birmingham City Hospital. When asked about her experience of midwifery services to date she told us,**

*"It's been really good. There is great communication and I get appointments really quickly. I get everything explained to me and after booking with the community midwife I was even shown around the maternity unit so I know where I will be going once I am ready to have my baby."*



### **She went on to tell us,**

*"I have a specific medical condition which means I have to have check-ups more often. My care here at the hospital has been great. I wish I could say the same about my GP though. I was even double booked there for an appointment and I have to wait ages to be seen. It's great coming here and all the nurses are really nice and I am always seen very quickly. It's stress free."*

### **We spoke with young people in care. When asked about the health assessments they have had they told us:**

*"I met with the school nurse for a medical. I knew it was going to happen and she was very civilised, I quite enjoyed it. She was laid back and relaxed which made it easy." He went on to say, "I've had a CAMHS assessment before as well and that was really good too. The doctor chatted to me and spoke to me like I was an adult."*

*"I had a medical at home, I didn't know it was going to happen and that didn't make me feel good, my friend just came to get me and told me there was a nurse at home waiting to see me. All the time it was going on (the medical) the nurse was talking to my carer and not me. I didn't like not knowing what was going on and why it was going on, it didn't seem fair."*

*"Mine was OK, I was told all about it and she chatted to me while she asked me all sorts of questions. She asked me about my weight my height, all sorts of things. I went to the doctors just the other day for a blood test. That was OK too, they told me what it was for and what was going to happen."*

### **Care leavers told us:**

*"I had my health review last week but didn't get a choice about where it happened. I had a questionnaire to fill out."*

*"The nurse was really nice. She was easy to talk to and made some notes, she said I will get a letter about it. My last health review was about 18 months ago. This was the first health assessment I ever had. She weighed and measured me and I was given a lovely goodie-bag with soaps and shower gels."*

*"I really didn't want a health assessment. I didn't like it as I had to have an injection. The nurse did explain things and I had met her before."*

### **Young people we spoke with told us they knew who to speak to if they had any concerns about their health and that they also knew how to obtain health promotion material if ever they needed to. One young person did tell us:**

*"I haven't got a clue where my school nurse is, I never see her. I know where the first aid room is at school but not the school nurse."*

### **Foster carers told us:**

*“Can’t fault the health service we have had. The school nurse is really helpful and always comes to see our foster daughter at home. The looked-after children’s nurse is available and I know I can ring her. I do find that helpful”*

*“The looked-after children’s nurse really reassured our foster child when he ran away from his health assessment. She was really very good with him. She talked to him about football and encouraged him to wear his football strip to the appointment so he felt comfortable. He then got on very well with the doctor, who asked his permission to examine him and explained each step of the medical; could he weigh him, the stethoscope might feel a bit cold: that sort of thing. The child was in control all the way. It made all the difference.”*

*“I always get a copy of the health report. This is helpful to refer to if I am looking after other children with similar issues.”*

*“The school nurse comes to visit us regularly. We know her well and she is lovely. She brought him lots of things like soaps and deodorants which he liked.”*

*“The looked-after children’s nurse has been fantastic, I have nothing but praise. They wanted to do the health review in school time but it’s really important the children don’t miss school and I work full-time so it would be difficult to take time out. The nurse really put herself out. She did the health review at home in the evening. The girls talk to her freely and trust her. The school nurses have also offered lots of help as they understand the problems our foster children have.”*

### **We heard about the training that foster carers can access:**

*“I did the “Keep” course which was for 12 weeks with other foster carers. It was about how to deal with children with challenging behaviours. We were able to share our experiences with each other and it was really helpful.”*

*“We can do all sorts of topic courses on-line. I did a first-aid course and I also did a safeguarding module to help me when the children have contact visits with their birth parents.”*

*“We’ve been on a restraint training course. This has really helped us in dealing with our foster daughter, who can be challenging.”*

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## The child's journey

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

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### 1. Early help

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- 1.1 We saw examples of good practice in all services we visited while also identifying areas for development. We saw examples of vulnerable children and families having access to a range of health and social care led early help support. Some we heard about were particularly innovative. For example; School Nurses are encouraged to join fortnightly Twitter discussion through a professional Twitter school nursing community to discuss topics such as forced marriage, female genital mutilation (FGM), and child sexual exploitation (CSE). This provides discussion and support at a national level that is disseminated locally ensuring advice and support is up to date and services are accessible to children and young people.
- 1.2 Vulnerable families needing early help support are able to access support services more quickly, since the provision of the multi-agency safeguarding hub (MASH), and the co-location of the early help team with the MASH. The monthly multi-agency community operating group (COG) meetings involving health, police, social care and other community workers, discuss local cases with known concerns to decide how best to support vulnerable children and families.
- 1.3 Assessments undertaken by midwives are good. Practitioners record not only the expectant mother's details, but also the father and all other siblings at an early stage. Antenatal support visits to the mother are routinely undertaken and clearly documented. Where concerns about risk or vulnerability are identified, a management plan is developed with the expectant mother's co-operation. Cause for concern forms are completed and sent to relevant agencies to facilitate the family's access to early help or higher levels of support from community services.
- 1.4 Specialist midwives provide effective care and support to teenagers who are pregnant. The family nurse partnership is also providing good support to young first time parents resulting in good health and wellbeing outcomes for children.

- 1.5 Where expectant mothers are living with psychological trauma, post-traumatic stress disorder or other recognised psychological disorders, the consultant midwife offers effective short-term care and support through weekly specialist clinics. Mothers needing longer-term specialist peri-natal mental health support receive services in a neighbouring area as there is no specialist service in Sandwell. Commissioners have not identified any gap in service for women living in Sandwell resulting from these arrangements and practitioners told us that women are able to access these services easily.
- 1.6 Health visitors' capacity to undertake ante-natal visits is increasing through increased service capacity resulting from the *Call to Action* implementation plan. We were told that home visits are currently undertaken mainly in response to vulnerabilities being identified by the midwifery service. This is being rolled out to become routine practice as part of the increased universal offer and all newly appointed health visitors are expected to undertake home visits routinely. However, we reviewed one case, where no home visit had been undertaken, although risks were identified clearly in the cause for concern form from midwifery. The health visitor had not contacted the midwife to explore the issues more fully and there was no recorded rationale for the lack of ante-natal visit. Although the practitioner told us that the case had been discussed in supervision where the decision not to visit at home had been made, there was no evidence of this discussion and decision on the case record. Other cases reviewed in the service further demonstrated this lack of practice oversight (**Recommendation 1.1**).
- 1.7 Joint visits with midwives are not often undertaken. More could be done to improve how the two services communicate, share information and co-ordinate activity, to ensure optimum support to vulnerable families with new born infants. Health visitors told us that it is not uncommon for new mothers to have visits from the two services at different times of the same day or within the same week. While there may be valid, risk-based reasons for doing this for individual cases, generally this lack of co-ordination can lead to duplication and put additional pressure on a new mother (**Recommendation 1.2**).
- 1.8 The Family Nurse Partnership (FNP) provides support to young first time parents. We saw a case example demonstrating good outcomes from this specialist intervention.

**Case example 1:** *A 16 year old in a relationship with a history of domestic violence, pregnant with her first child, was referred to the Family Nurse Partnership from the pupil referral unit (PRU). There was a history of drugs use, mental health issues and domestic violence across the young person's extended family. The unborn baby was made subject to a child protection plan and agencies worked closely to support her during pregnancy; this included joint visits between the FNP practitioner and the midwife.*

*On giving birth, mother and baby moved into a mother and baby foster placement but this quickly broke down and the young mother absconded. Throughout this period, although reluctant to work with agencies, the young person maintained engagement with the FNP practitioner with whom she had forged a good relationship.*

*As a result of the stability and constant support of the FNP service, the young person has continued to parent her baby effectively although the situation remains fragile and the child protection plan remains in place.*

*The young mother is more open to the support being offered and is more candid with professionals who continue to work closely with her. She is taking a baby massage course and has registered herself and the baby with a GP. The plan is for her to move into semi-independent mother and baby accommodation.*

- 1.9 When families move between areas in Sandwell, handover arrangements between health visitor teams work well. Practitioners meet face-to-face to transfer cases and we reviewed a number of case examples demonstrating this good practice.
- 1.10 When requiring emergency treatment at the acute hospital, young people aged between 16 and 18 are offered the choice of receiving care in the paediatric or adult emergency department. The dedicated paediatric waiting and assessment area is not open 24 hours per day. In part this is due to difficulties in providing paediatric trained staff and capacity pressures. When closed, young people are directed to individual cubicles to await treatment. This can result in vulnerable young people waiting in areas that are not routinely supervised by staff members and where cubicles are also used by adult attendees to the emergency department (ED). A lack of staff's ability to directly oversee children and young people in these areas may place those young people at risk (**Recommendation 1.3**).
- 1.11 We observed some good safeguarding practice in the ED in relation to a child attending for a head injury. The practitioner established parental responsibility and that the child was known to children's social care and contacted the child's social worker who undertook to follow up with the child's parent.

- 1.12 Adult attendance cards in ED do not prompt practitioners to ask specific questions about children within the family or wider household. Reliance is placed on the health professional to ask these questions and while we were told that practitioners do seek this information routinely, we did not see evidence of this on the adult attendance cards reviewed. This creates a risk that children and young people at risk of hidden harm may not be identified (**Recommendation 1.4**).
- 1.13 While questions regarding parental responsibility and social care involvement are included in attendance cards for under 18s in line with NICE guidance, in most cases we reviewed, these details had not been completed. In one case we reviewed, a child had ingested cleaning fluid. Other than offering advice about safe storage of chemicals, there was a lack of professional curiosity, with no evidence of the practitioner asking questions or seeking information about the circumstances of the incident. As a result, there was no assessment of the wider risks to the child or any siblings (**Recommendation 1.5**).
- 1.14 Young people attending the ED with emotional ill health or having self-harmed have good access to child and adolescent mental health service (CAMHS) assessment Monday – Friday via admission to the paediatric ward. This care pathway is well established and trust staff told us that CAMHS generally respond promptly to requests for assessments, responding on the same day if contacted before 11am. There may be delays in children being assessed by CAMHS between the afternoon on Fridays and Monday morning, however. Out of hours, consultation and advice is available from the adult mental health department at Hallam Street Hospital. This can challenge paediatric staff in meeting the child's needs while caring for other children on the ward. The nursing team obtain agency registered mental health nursing (RMN) support when acutely disturbed children need one to one care. Lesser degrees of supervision are provided by paediatric nurses as appropriate.
- 1.15 Referral pathways for children and young people needing contraception and sexual health services (CASH) or children's drug and alcohol services (DECCA), are less clearly understood by trust practitioners (**Recommendation 1.6**).
- 1.16 Young people benefit from the therapeutic intervention of the Black Country Partnership Trust (BCP) CAMHS service. This is very child led and we saw and heard case examples where intervention had resulted in good outcomes for young people. Practitioners are sensitive in their intervention which is conducted at the child's pace to secure the child's engagement. However, it is not always clear what the goals of the intervention are from the child's case record. The service's approach to care planning, managerial monitoring and practitioner's analysis and evaluation of progress is underdeveloped and not reflected in case recording. The service acknowledges this as an area for development (**Recommendation 2.1**).

- 1.17 School nurses provide effective health education to schools in the Sandwell area. This is provided according to the specific requirements of individual schools, including targeted work to introduce healthy diets to schools where obesity is a known issue. The school health team maintain a table of trends according to individual schools so that they can target health promotion according to need. This is pro-active; facilitating prompt and flexible advice and guidance to young people, when needs or “hot topics” may arise quickly in particular areas of the borough. There are close working relationships between school nurses and CAMHS. School nurses have clear pathways to refer young people to the *My Shield* support service. The interactive counselling therapies for young people include drama and music therapies which are provided by *My Shield* and are well regarded by referring agencies.
- 1.18 Children and young people have good access to contraception and sexual health services (CASH), through school nurses, family planning and the Brooke Advisory Service. We saw cases where young people had received sensitive and timely support. Liaison between the services was prompt and effective. Care plans developed by school nurses working with individual young people are SMART and person centred with the voice of the child clearly in evidence. The roll-out of the drop-in service providing young people with sexual health advice and sexually transmitted infection testing, following a successful pilot, is a positive and innovative development. This is being delivered in a partnership between school nursing, family planning and the Brooke Advisory Service. However, risk assessment in both Brooke and the family planning service is underdeveloped with no robust risk assessment proforma to guide practitioners in seeking information about partners and to ensure that risks of CSE and FGM are fully considered. CQC will draw the local authority’s and public health’s attention to these issues.
- 1.19 The vulnerable children’s team within the school nurse service provide effective care and support to-hard-to reach families. This includes the travelling community, young people being educated at home, children and young people who attend a pupil referral unit and families new to the UK not accessing education. We were told how an ‘electronic health passport’ is being planned at the request of travelling families so that they can carry relevant health information with them when out of area. This has the potential for being highly effective in ensuring the health and wellbeing of traveller children should they need urgent medical care while in other parts of the country.

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## 2. Children in need

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- 2.1 Sandwell General Hospital ED is attended in the main by children and adults who live either in Birmingham or Sandwell. Where clinicians identify safeguarding concerns about children and young people, referrals made to Birmingham children's social care and Sandwell children's social care require the completion of separate referral forms. If the referral is not made to the correct area the referral is returned to the practitioner making the referral for re-sending to the correct area. An ED practitioner told us about a case where the referral had been returned to the practitioner who was on leave for a few days, resulting in the referral sitting in the in-tray until the worker's return to work. This could cause significant delay if the worker was absent from work for some time. This could present risk to children and young people who might require urgent assessment. The local authority area in which ED patients live is not identified and recorded at registration currently and practitioners are not always able to identify the correct area easily later on in the child's journey through the department (**Recommendation 1.7**).
- 2.2 Health visitor attendance at GP practice meetings is not consistent across the borough and therefore, the approach to information sharing about vulnerable families and children is variable. In one GP surgery we visited there was co-location of health visitors and the linked health visitor regularly attended practice meetings. This is effective in facilitating information sharing about vulnerable families within the practice. However in the second practice visited where there is no co-location, although access to health visitors was described as good, there is no health visitor attendance at practice meetings. This is a lost opportunity to share current information and any safeguarding concerns about vulnerable families and signpost them into early help or higher levels of support (**Recommendations 1.8 and 3.12**).
- 2.3 The GPs we met are routinely advised of children and young people's attendance at the ED. We were told that they review the information placed on the information management system used by most Sandwell GPs and health providers. If the GP has any concerns regarding the nature of the attendance, they will either invite the person to attend surgery for a review, or ensure the information is shared with health visitors so that they can take further action.
- 2.4 GPs are aware of the multi-agency risk assessment conference (MARAC) process and how to submit information if required to inform those decision making forums. Both surgeries had provided domestic violence awareness training to their staff, with one surgery using innovative ways to inform potential victims of domestic violence help line contact details and literature. Examples of the methods employed to pass discrete information included giving out phone line pens.



- 2.5 The Black Country Partnership Trust adult mental health service has strengthened its approach to risk assessment and the identification of the client's contact with children other than those for whom they have parental responsibility. We saw case examples where the service had initiated CAFs to good effect. The service is working towards establishing *Think Family* practice although this is not embedded (**Recommendation 2.2**).
- 2.6 The trust notifies the Care Quality Commission appropriately in line with guidance. In the last year the CQC were notified on four occasions that a child had been admitted to an adult psychiatric ward based at the Black Country Partnership NHS Foundation Trust. In one case there was no available local CAMHS bed and the minor was due to turn 18 years of age within a few weeks of admission a decision was taken that the admission was appropriate. In two cases, minors were admitted due to no CAMHS beds being available and were discharged home within two days of admission. In a further case a child was admitted to an adult ward as there was no available CAMHS bed, the young person was transferred to a CAMHS provision within five days after admission. In all four cases a CQC inspector followed up these notifications with the trust, all four cases are now closed to CQC.
- 2.7 Escalation policies are in place within agencies to support the resolution of professional differences. The Stockport Safeguarding Children's Board (SSCB) Resolution and Escalation Policy was approved in April and has been available on the SSCB website from July 2014.
- 2.8 In cases where health visitors, adult mental health and/or substance misuse services are working with a family where risks have been identified, there is a lack of routine direct liaison and information sharing between these services. Health visitors also told us that they do not always know when adult health services are involved with a family. This lack of effective communication between services is a frequent feature in SCRs and can undermine effective multi-agency responses to family situations and risk. For example; it can result in health visitors not having sufficient information to be able to identify when parents may be at risk of a mental health or substance misuse relapse. Increased risk of harm to a vulnerable child may not be recognised promptly as a result, leading to delays in professionals taking protective action (**Recommendation 1.9**).
- 2.9 There is a low awareness of *Think Family* as a model of practice in the adult substance misuse service and we did not see evidence of the service working towards establishing this model. Neither did we see case evidence that all practitioners prioritise children's safety while working with the adult (**Recommendation 4.2**).

- 2.10 Adult substance misuse practitioners are not routinely participating in discharge planning from maternity when there are significant risks identified or child protection plans in place for new-borns. Their input may be key to ensuring the new family is properly supported and discharge plans are comprehensive and robust. Communication with other services, such as health visiting, is not routine and there may be an over reliance on information being given by their client who may not always be a reliable source (**Recommendations 4.3** and **4.4**).
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### 3. Child protection

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- 3.1 In all services, including those primarily working with adults, and in most cases we reviewed, we saw determined efforts by practitioners to engage with their clients to ensure that vulnerable families and families subject to child protection processes are supported effectively.
- 3.2 We saw little evidence of routine and regular communication and liaison between health professionals working with children and adults where there are known to be significant concerns and child protection plans are in place. There is rarely direct liaison between health visitors and adult service practitioners in mental health or the substance misuse service. As these may be the health professionals most involved with the child and parent and therefore needing to work cohesively, this is a gap. There is an over-reliance on formal child protection meetings as a means of inter-service communication. This is an area for development as lack of inter-agency communication and information sharing is a feature of all Serious Case Reviews (**Recommendations 1.9, 2.3, 4.4**).

**Case example 2:** *One of the cases which we tracked across services strongly evidenced the need for routine and regular liaison between services, particularly where parents may not be a reliable source of information. Indicators of risk were not being picked up and responded to appropriately.*

*The parents had disengaged from services and professionals were not gaining access to the home to see the children.*

*The children were very overdue for developmental assessment by the health visiting service and the case drifted for a considerable time within the service without being discussed with operational managers or in supervision.*

*Concerns about the mother's physical condition and unreliability of her accounts of being drug free were identified in the substance misuse service but did not result in the service making a referral to the MASH.*

*This case has had a positive outcome ultimately, with the MASH response to a medical crisis for one of the children being crucial in achieving a positive outcome. The children are safe, having been taken into care, giving all agencies and practitioners an opportunity to learn significant lessons from this case.*

- 3.3 For the most part however, health practitioners are identifying safeguarding concerns appropriately and making referrals to the MASH using the multi-agency referral forms. Since the revision of the threshold document, provider agencies report that practitioners have greater clarity of understanding of the thresholds for referral. We reviewed multi-agency referral forms (MARFs) in a number of services. Whereas we did not see any that were poorly completed, we did see MARFS where the actual risk of significant harm to the child was not clearly set out. It was not always clear what the referrer was hoping to achieve by making the referral. This is an area for development across most health services. As an example, in one MARF generated by CAMHS, the referrer stated that they thought the family would benefit from having an assessment rather than what was expected as an outcome of children's social care intervention. We saw an example of a good quality MARF in our visit to IRIS, adult substance misuse service. This was concisely written, avoided the use of overly clinical language and expressed clearly the practitioner's level of concern of risk of harm to the child (**Recommendations 1.10, 2.4, 4.5**).
- 3.4 We saw good use of genograms by school nurses and the family nurse partnership. This helps practitioners and managers understand the structure of a family and can also be used to identify where risk to children is presented by family members or significant others and their use is good practice.

- 3.5 Health practitioners in Sandwell are committed to ensuring the safety of children and young people. All services prioritise attendance at child protection conferences and the submission of written reports as required. In most of the cases we reviewed, we saw evidence of practitioners attending conferences.
- 3.6 GP practices visited have appropriate flagging systems in place to alert staff where child protection or CIN plans are in place, linked to parental records. When children and young people are removed from child protection measures the alert is retained on the system enabling those accessing the information to see that there have been previous concerns. However, overall, GP engagement in safeguarding and child protection arrangements remains an area for development. Attendance of both GPs and adult mental health practitioners at child protection conferences is reported by the CCG to have improved, although it remains at a low level. Neither GP practice we visited participated in child protection conferences although they received information from them. It is not clear whether the potential for the use of technology such as teleconferencing has been explored to increase GP participation and engagement in child protection conference discussions and decision making (**Recommendation 3.1**).
- 3.7 Health services, including adult mental health and substance misuse, do not always ensure that they have received child protection and CIN plans and that these are well secured with the case record. Without the child protection plan, practitioners cannot be clear on what their role in safeguarding the child is and it is difficult for managers to ensure best practice. There was little evidence that practitioners established more detailed service plans with their client when child protection plans were in place.
- 3.8 In the health services visited, we did not see evidence of child protection plans broken down into a more detailed service plan. The absence of detailed service plans makes it difficult for practitioners to identify a parent's non-compliance with the child protection plan and what to do when they identify non-compliance (**Recommendations 2.5** and **4.6**).

- 3.9 Where children or parents of children with identified vulnerabilities or subject to child protection plans did not attend health appointments, we did not see sufficiently robust responses in all services to ensure the child was safe. Where practitioners do not adhere to 'did not attend' (DNA) protocols this can lead to elevated risks to children not being responded to promptly and may lead to children not being effectively safeguarded. This was demonstrated in case example 2 in this report, where the children had not attended developmental check appointments either at home or at nursery and the parent had failed to attend their own appointments with the substance misuse service. It was not clear that practitioners had followed the respective services' DNA policies. We were told that DNA policies are in place within all health agencies although some policies are currently under review. Managers in services told us these are single agency policies; a shared multi-agency DNA policy overseen by the LSCB is being developed (**Recommendations 1.11, 2.6, 4.7**).
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## 4. Looked after children

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- 4.1 In January 2013, an audit of 79 cases found that more than 50% of initial health assessments (IHA) were undertaken after the initial statutory review which is held six weeks after the child became looked-after. Of the 79 cases, five children had their initial health assessment 100 days after their first statutory review. Currently, 85% of children can expect to have had their initial health assessment (IHA) within 20 days of the health looked-after children's team receiving notification of them coming into care. This represents a significant improvement over the past 18 months. Initial health assessments are currently being completed within 20 days of the notification being made.
- 4.2 IHAs are completed by the designated doctor who is a consultant paediatrician and this is good practice in line with guidance. If a young person coming into care aged 16 or over elects to have their review completed by a GP, or consultant of the same sex then this is arranged with the oversight of the designated doctor. Performance on the completion of IHAs within timescales has improved through the creation of increased clinic capacity and improved processes of notification from children's social care. Although there is more to do to ensure a fully rigorous whole system approach, positive progress has been made.

- 4.3 Information provided by other services to inform health assessments for looked-after children is patchy and inconsistent. In one IHA, information was supplied by a GP about CAMHs involvement with the child. This was information essential to both the clinician and to the foster carer, who had been previously unaware of the child's significant mental health issues. This demonstrates how important it is that all known health information is gathered and all health needs identified to inform a comprehensive assessment and health plan for the child (**Recommendations 2.7** and **3.2**).
- 4.4 In the IHAs reviewed, while there was good inclusion of the child's birth history, there was little or no information about parental health history. Partner agencies need to ensure this information is transferred to the looked-after child health team to inform IHAs and subsequent health reviews. Equally, the looked-after child health team have a responsibility to ensure that they receive the information and that it follows the child. Care leavers regularly tell us how important it is to them that agencies ensure that this information stays with them on their journey through health and social care. They tell us how it can have a significant and detrimental impact on them as young adults when this information is "lost" at the start of their journey as it can only be captured at the point the child becomes looked after (**Recommendation 3.3**).
- 4.5 We observed sensitive, comprehensive and child centred initial health assessments being undertaken by the designated doctor, who is skilled at engaging the child in the process and drawing the personality of the child out. This good quality and child centred approach was not reflected in the IHA documentation we reviewed however. Completed IHAs were quite basic in content and while there was some sense of the personality and individuality of the child, this was not strong and there was little evidence of the voice of the child (**Recommendation 3.4**).
- 4.6 Good consideration is given to cultural, religious beliefs and gender issues for children and young people in both IHAs and health reviews. This is important as cultural needs may inform how health support can best be delivered to the child or young person. Interpreters are routinely provided and we observed an older child being given choices about having a same sex clinician undertake the assessment and who could attend.
- 4.7 Review health assessments (RHAs) are largely undertaken by school nurses who have received training. Appropriate consent is obtained prior to any IHA or RHA taking place and confirmed at the assessment. Young people who are able are encouraged to give their own consent helping them to engage with managing their own health and wellbeing. Young people have choices about where their review health assessments take place and typically, this could be in school, at their foster or residential placement or at a clinic.

- 4.8 Healthcare plans resulting from IHA and RHA's were not generally SMART or sufficiently specific to the child or young person; being often generic in nature with some loose timescales and accountabilities (**Recommendation 5.1**).
- 4.9 Looked-after children have good access to a specialist CAMHS service and benefit from this specialist therapeutic support. Where young people who are no longer in care are identified by CAMHS as being likely to become looked after again, they continue to give support to the young person. This is helpful in giving a child a sense of stability and continuity. We heard very positive feedback about the service from a young person. However, when young person with mental health needs are returning to the borough from out of area placements, CAMHS is not always aware of their return and this can result in poor planning and a poor transition experience for the child (**Recommendation 2.8**).
- 4.10 Support to care leavers is being developed and the provision of a dedicated nurse for this cohort is very positive facilitating improvement in this recognised area for development. Care leavers are not given a full health history or passport but receive age appropriate health information which they have helped develop and a letter setting out their birth history (**Recommendation 3.5**).

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## Management

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

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### 5.1 Leadership and management

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- 5.1.1 The investment by the CCG in the development of the safeguarding and looked-after children's team is positive and innovative, providing focus and leadership while providing the constant health presence and expertise in the MASH. The CCG have also appointed a strategic lead within the safeguarding team for domestic abuse. This role will be involved with domestic homicide reviews work and provide leadership across the health economy on domestic abuse which has been identified as a significant local issue. The development of this strong infrastructure in the CCG to lead and oversee safeguarding and health support to looked-after children is commendable, providing an excellent framework to drive improved outcomes for children and young people across the health economy.

- 5.1.2 The development, establishment and operation of the MASH which launched in November 2013, is impressive. The model that has been established is robust, with significant investment and commitment from all key partners. Although only recently established, there is evidence that vulnerable children are gaining appropriate support more quickly and children at risk are being protected. Governance arrangements are developing well and include the quality assurance of MARFs. The way that the CCG safeguarding team manage their MASH activity on a rotational basis is pragmatic and robust; very supportive of both clinical and non-clinical staff in dealing with what can be intense case work.
- 5.1.3 It is evident that the inception and establishment of the MASH has acted as a catalyst to the improvement of multi-agency partnership working in Sandwell. Historically, this has not been strong. However, all agencies across the health and children's social care interface with which we met, describe much improved relationships. Where there are professional differences, debate and dialogue is described as open, healthy and mature. This is very positive and a good foundation from which to progress in the development of an effective whole system approach to the provision of support to looked-after children and multi-agency safeguarding of children and young people.
- 5.1.4 The MASH's work on the identification of risks to children has very recently been enhanced by Sandwell and West Birmingham Hospitals NHS Trust agreement to the MASH health practitioners having read only access to the trust's electronic records system. This enables the health practitioner in the MASH to check quickly whether children have accessed emergency treatment and how frequently. This enriches the information available to the MASH, helping to inform optimum decision making and demonstrates clearly the trust's commitment to safeguarding children across the borough working in partnership with others.
- 5.1.5 Partnership between the CCG and NHS England is developing well. An agreement has been reached whereby the area team is to fund a named GP post, or appropriate equivalent model, with the CCG directly employing them. The development of a jointly agreed work programme to develop the named professional's role and expertise is in hand. Primary care will benefit from having a more directly accessible and identifiable lead professional in place; providing leadership and focus to increase GP engagement in safeguarding and looked-after children arrangements.
- 5.1.6 The designated nurse for looked-after children is recently appointed and has a significant improvement agenda on which she is working with children's social care and the designated doctor. The current absence of the dedicated looked-after child nurse for care leavers is putting additional pressures on the designated nurse's capacity as she is covering this role. An action plan is in place, although the team acknowledge that the plan does not set out easily measurable objectives making it more challenging to track progress (**Recommendation 3.6**).



- 5.1.7 An operationally focused health and social care group is being established which the specialist CAMHS looked-after children's service is to join. This will help to drive improvement across the service interfaces. The designated looked-after children's nurse has recently begun to hot desk once a week with the children's social care looked-after child team. This is facilitating the development of a whole system approach as the nurse is able to provide active support and encouragement to social workers to ensure appropriate documentation is completed promptly.
- 5.1.8 The named midwife for safeguarding is not currently supported by an up-to-date role description. This is not in line with current guidance. The named midwife covers safeguarding in all multi-disciplinary areas in both Sandwell and Birmingham and has significant capacity pressures due to the span of her portfolio. Similarly, named nurses in the trust provide safeguarding support and one to one supervision to the acute hospital and community health service. We understand the trust is currently reviewing roles and job descriptions (**Recommendation 1.12**).
- 5.1.9 While the presence of the Black Country Partnership Trust named nurse in the MASH two and a half days per week is valued, this does limit her capacity to develop safeguarding practice within children's and adult services within the trust. Also MASH's access to information about adults who may present risk and children who may be at risk of harm is significantly reduced when there is no trust presence at MASH for half the week. We understand that the trust is committed to increasing its presence in the MASH and action is being taken to recruit additional staff resource although this is taking longer than expected (**Recommendations 2.9, 2.10**).
- 5.1.10 Additionally, as the trust does not have an electronic records system in place, this makes effective communication and prompt access to mental health clinical expertise more challenging. Practitioners within the mental health service told us of their frustrations in trying to share information effectively both with the MASH and other services while operating with a hard copy recording system. While at the MASH, we observed a multi-agency discussion about a case where input from the mental health trust would have been helpful to the decision making process. This is an area for development which is acknowledged by the trust but the timescales for resolving the recruitment issue and moving to an electronic system were not clearly understood across the partnership at the time of this review (**Recommendation 2.11**).
- 5.1.11 The adult substance misuse service, IRIS, is new; having launched in February 2014 and the service's approach to children's safeguarding is significantly under-developed. The service does not have a safeguarding lead and is not engaged with the wider safeguarding arrangements operated by the CCG safeguarding team. The service is very aware of its responsibility to safeguard children, is keen to establish effective safeguarding practice across the service and is developing a virtual link with the MASH (**Recommendation 4.1**).

- 5.1.12 Child sexual exploitation (CSE) is recognised among providers as a risk to children and young people living in Sandwell. There are also increasing numbers of mothers to be, who are themselves victims of female genital mutilation (FGM), accessing maternity services raising the need for all health providers to ensure practitioners are able to identify and act upon these risks in their dealings with children and young people. A panel to respond to the issue of young people at risk of sexual exploitation (YPSEM) is in place. This has membership from a range of agencies including health facilitating a good approach to the issue at a multi-agency level. However, a number of practitioners from different services have told us that they do not feel fully skilled and equipped to recognise the indicators which may suggest a child or young person is at risk from CSE or FGM in their day-to-day work (**Recommendation 3.7**). We will draw this issue to the attention of the local authority and public health in relation to health services which they commission.
- 5.1.13 The widespread use of a single electronic record system across the health economy, including most GP practices is highly beneficial in facilitating good information sharing. Safeguarding leads within GP practices have now been identified and we have been told that a GP safeguarding forum has been established where practitioners can access additional peer safeguarding support, develop their expertise and gain support in their role of developing safeguarding activity within their practice area. However, neither practice we visited was aware of the forum (**Recommendation 3.8**).
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## 5.2 Governance

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- 5.2.1 The Sandwell and West Birmingham CCG recognised the need to prioritise the transfer of the designated roles into the CCG in order to clarify commissioning and governance arrangements; achieving this early in its first 18 months of operating. There is a consensual view across the partnership, between the health economy and social care that the CCG has brought in strengthened governance arrangements, giving clear direction to providers on the expected standards of service delivery. It is achieving this while supporting providers in delivering improved outcomes. The development of the safeguarding dashboard, incorporated into provider contracts with explicit safeguarding performance expectations is indicative of this stronger approach to governance. As is the introduction of the performance accountability board (PAB) and robust reporting process.
- 5.2.2 The CCG has commenced its 2014/15 Vulnerable People and Families Assurance Visits of its providers. The reports for Sandwell and West Birmingham Hospital and Black Country Hospital will be submitted to the quality and safety group once finalised. Both provider and CCG told us that the recent assurance visit of the Black Country Partnership NHS Trust had been a positive experience for both parties.

- 5.2.3 Children's social care has recently established an effective notification process for when young people come into care. The CCG team have put appropriate mechanisms and systems in place to support effective governance and monitoring of health performance on IHAs and RHAS reported to the PAB and performance is improving, albeit from a low base. We saw evidence of clinic appointments for IHAs being booked on the day that the notification was received.
- 5.2.4 Introduction of BAAF documentation has successfully brought consistency to the undertaking of IHAs and RHAS. Using the form electronically facilitates effective information sharing. There is no quality assurance of IHAs undertaken by clinicians external to Sandwell when children are placed out of borough however and this is a gap (**Recommendation 3.9**).
- 5.2.5 Young people have good opportunities to meet regularly with the looked-after children's designated nurse and participate in the development and governance of looked-after child arrangements through their attendance at the corporate parenting board. The designated nurse also helps run the initial health assessment clinics giving children and foster carers the opportunity to meet her and enabling her to develop direct knowledge of the looked-after cohort. The designated nurse's introduction of her regular health blog in the foster carers' newsletter is another positive development.
- 5.2.6 Sandwell and West Birmingham Hospitals NHS Trust is strengthening its governance of safeguarding activity across the trust, with the benefit of having recently established a safeguarding team structure. The designated doctor is committed to the role and provides leadership through her visibility and hands-on approach. She is working with the named GP on developing appraisals and works closely with the CCG safeguarding team with a clear vision of how she wants to continue to develop the role, although capacity pressures can limit the opportunities to do this.
- 5.2.7 The provision of a paediatric liaison nurse role in the trust is very positive, enabling a daily review of all attendance cards for under 18s to take place. The details of attendances at the unit are then forwarded to GPs, health visitors and school nurses as required. The paediatric liaison nurse also quality assesses referrals made to the MASH and when reviewing attendance notes will also question why a referral has not been made when they consider it would have been appropriate. Given the lack of completion of attendance cards and absence of detail of how safeguarding risk has been assessed in cases, it is difficult to ascertain how effective this quality assurance is however (**Recommendation 1.1**).

- 5.2.8 Work is underway within individual health services to better understand why the recent audit of the attendance of health practitioners at child protection conferences showed low attendance across the health community. This is particularly surprising in relation to school nurses and health visitors where we commonly see high levels of attendance. Data held within the school nursing service supports that school nurses, where informed, attend more than 90% of initial child protection conferences. Managers and practitioners in all services are clear that attendance is prioritised and cover arranged whenever possible if the case worker cannot attend.
- 5.2.9 Since June 2014, the CCG safeguarding children unit are now the single point of contact for both reports and invitations to initial child protection conferences for GP's, health visitors, school nurses, midwives and paediatricians. Additionally, in recognition of this area for development, the school nurse service has set up a central mailbox to receive notifications. The account is to be checked daily by senior school health staff so that requests can be directed accordingly, allowing for staff leave or sickness. This proactive and solutions focused response appears typical of what we found when we visited the school nursing service.
- 5.2.10 Operational management approaches to ensuring effective safeguarding practice within provider services are generally underdeveloped. We saw case examples of this in the health visitor service and adult mental health and substance misuse services. Examples of this under development include: provision of effective monitoring of attendance at CIN and child protection meetings and monitoring safeguarding practice through routine quality assurance of case records. (**Recommendations 1.1, 2.2, 4.2**).
- 5.2.11 We saw particularly strong young peoples' involvement in developing school health services. Health professionals have proposed the development of smart phone applications that young people can download so that they can comment on their own patient experience. Other applications are planned for development to further enhance user involvement and this is innovative thinking.
- 5.2.12 While CAMHS practitioners are effective in enabling young people to guide and steer intervention with them as individuals, there is scope for Black Country Partnership Trust to further develop how it hears the child's voice about their experience of the service. We were told that there is no active peer support and consultation group for young people engaged with CAMHS although we were told they would welcome this. In the waiting area there is a feedback box for young people to use, however, we were told by a young person using the service that young people have to ask for a feedback form at the reception desk and they find this off-putting (**Recommendation 2.12**).

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## 5.3 Training and supervision

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- 5.3.1 Midwifery safeguarding training at level three currently stands at 77% and this is an area for development. Attendance at training is monitored closely. However, initial level three training is currently multi-disciplinary rather than multi-agency. Level three refresher training is, where possible, provided in multi-agency groups. We are aware that safeguarding training provision is currently under review within Sandwell and West Birmingham Hospitals NHS Trust (**Recommendation 1.13**).
- 5.3.2 Brooke Street practitioners are currently trained to safeguarding level one, not only is this not in line with statutory and inter collegiate guidance, but equipped only with this most basic level of safeguarding training, it is very doubtful that practitioners have sufficient knowledge and skills to discharge their safeguarding responsibilities effectively and this is a priority area for development. We have drawn this issue to the attention of the local authority and Public Health who commission the service.
- 5.3.3 Practitioners at the ED told us that there are delays in being able to access safeguarding refresher training at level three, with some staff going beyond three years before they are able to undertake appropriate training meaning their safeguarding training status expires. When safeguarding training at level three is provided it is multi-disciplinary and not multi-agency and therefore not fully in line with statutory guidance.
- 5.3.4 While most health practitioners have received training on the new MASH thresholds, the newly commissioned IRIS, substance misuse service has yet to access this training as no places have been available. This is recognised in the service and by children's social care as a priority. When we visited the service, managers and practitioners were unaware of the thresholds document and had not seen a copy. There was more to do to ensure that all front-line practitioners undertake level 3 children's safeguarding training in line with guidance (**Recommendation 4.8**).
- 5.3.5 Some health practitioners in other services told us they felt that the training had not really prompted staff to complete MARFs based upon the thresholds document. We are aware the training has just been evaluated and the outcome of the evaluation was expected at the time of the review.

- 5.3.6 Safeguarding supervision arrangements for staff in the ED are good, with group supervision on a three monthly basis where cases are discussed. This gives good opportunity for peer support and shared learning. Safeguarding supervision arrangements within midwifery services are not robust however and not in line with guidance. Supervision is undertaken on an ad-hoc basis or when requested by the practitioner. Sandwell and West Birmingham Hospital Trust are aware of the issue and we were told that a review of supervision arrangements is currently underway (**Recommendation 1.14**).
- 5.3.7 In most services, we did not see routine recording on the client record of when cases are discussed in supervision and the decisions taken in line with best practice. In health visiting, a decision was taken in supervision that an antenatal visit was not needed in a case even though risks had been clearly set out on the cause for concern form sent by the midwife but not rationale for this was recorded inhibiting effective operational monitoring of practice through the case record (**Recommendation 1.1**).
- 5.3.8 While GPs we visited have good access to the named GP for advice and guidance, safeguarding supervision is ad-hoc at the request of individual GPs and not according to a structured, planned process in line with statutory guidance (**Recommendation 3.10**).
- 5.3.9 Named nurses value the supervision they receive from the designated nurse. However, there is no local safeguarding named professionals' forum where named nurses and lead safeguarding professionals can meet regularly to gain peer support and share common issues and good practice across the agencies (**Recommendation 3.11**).
- 5.3.10 Good quality training on FGM has been delivered by the police and it is clear that there is a need for further training to be provided to raise practitioners' understanding and skills to ensure they are able to include consideration in their everyday work of the risks and potential for CSE and FGM. This was evident in the ED and particularly in the family planning and Brook service where staff recognised they lack training on these issues and where a wide and in depth understanding is essential to their safeguarding practice (**Recommendation 1.15**).
- 5.3.11 Safeguarding supervision within public health is robust. Safeguarding supervision for school nurses has been introduced as per Birmingham Community Healthcare's policy which is 1:1 supervision with a safeguarding children's named nurse. As at the end of July 2014, just prior to this review compliance was at 84.62% and by the end of August was 100%.

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## Recommendations

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- 1. Sandwell and West Birmingham CCG and Sandwell & West Birmingham Hospital Trust should:**
  - 1.1 Ensure that effective practice governance, supervision and operational oversight arrangements are in place to monitor practitioners' compliance with service delivery expectations and best safeguarding practice and record keeping.
  - 1.2 Establish a regular liaison forum between the midwifery and health visiting service to ensure effective information sharing and communication arrangements are in place and that joint visits are undertaken as appropriate to support vulnerable families.
  - 1.3 Ensure that children and young people waiting for treatment in the emergency department when the paediatric area is closed are subject to effective staff oversight and waiting arrangements which minimise risk of harm.
  - 1.4 Ensure that staff in the emergency department assessing adults who attend for treatment are fully supported to identify risks of hidden harm to children through the provision of appropriate trigger questions on attendance cards and that completion is subject to effective operational monitoring.
  - 1.5 Put effective quality assurance and safeguarding practice oversight arrangements in place to ensure emergency department staff routinely undertake comprehensive child safeguarding risk assessment and complete documentation to the expected standard.
  - 1.6 Ensure that care pathways for young people requiring support for substance misuse or sexual health are established and well understood by emergency department practitioners.
  - 1.7 Ensure that the local authority area in which adults and children attending the emergency department reside is identified at the point of registration to minimise the risk of any delay in protective action being taken in the event of a safeguarding referral being made.
  - 1.8 Ensure that health visitor attendance at GP practice meetings is consistent and routine across the borough to ensure effective communication of the identification of vulnerabilities and facilitate the provision of early help support.
  - 1.9 Ensure that health visitors liaise routinely with adult health services in all cases where there is multi-agency support to vulnerable families or where there is a child known to be at risk.

- 1.10 Ensure that referrals to MASH are concise, avoiding the use of clinical language and set out the risks of actual harm to the child or young person clearly to best inform decision making about the level of intervention required.
- 1.11 Ensure that there is a current and robust DNA policy in place in the health visitor service and that practitioners demonstrate compliance.
- 1.12 Ensure that there is sufficient capacity in the trust's safeguarding team of designated and named professionals to drive the safeguarding improvement agenda and undertake all roles and responsibilities set out in updated and comprehensive job descriptions.
- 1.13 Ensure that practitioners in all trust services undertake safeguarding training at a level commensurate with their roles and responsibilities including multi-agency training at level three in full compliance with statutory guidance as set out in *Working Together 2013*.
- 1.14 Ensure that all midwives receive formal, planned and recorded safeguarding supervision on a regular basis in line with statutory guidance set out in *Working Together 2013*.
- 1.15 Ensure that practitioners in the emergency and other departments as appropriate undertake training on female genital mutilation and child sexual exploitation to fully inform their safeguarding practice and risk assessment.

**2. Sandwell and West Birmingham CCG and Black Country Partnership Trust should:**

- 2.1 Ensure that all therapeutic interventions are subject to robust care planning, monitoring and evaluation of child-centred outcomes.
- 2.2 Ensure that *Think Family* practice is embedded across the adult mental health service and that practitioners demonstrate that they routinely prioritise the safety of children in their everyday work and case recording.
- 2.3 Ensure that mental health practitioners liaise routinely with health visitors and other disciplines in all cases where there is multi-agency support to vulnerable families or where there is a child known to be at risk.
- 2.4 Ensure that referrals to MASH are concise, avoiding the use of clinical language and set out the risks of actual harm to the child or young person clearly to best inform decision making about the level of intervention required.
- 2.5 Ensure that where a child in need or child protection plan is in place, that the current plan is on the case record and the practitioner has established a more detailed service agreement with their adult client to underpin this plan.



- 2.6 Ensure that there is a current and robust DNA policy in place and that practitioners demonstrate compliance.
  - 2.7 Ensure that where a looked-after child is known to CAMHS, information from the service intervention routinely informs initial and review health assessments.
  - 2.8 Work with Sandwell Borough Council to ensure that looked-after children returning to the borough from out of area placements who have received CAMHS support external to Sandwell, experience seamless transitions back into local CAMHS support.
  - 2.9 Ensure that there is sufficient trust presence and participation in the MASH arrangements to best support prompt recourse to clinical expertise to facilitate optimum decision making and good outcomes for children and young people.
  - 2.10 Ensure that the named nurse role has sufficient capacity to drive and oversee improvements to safeguarding practice within the service and that the post-holder is fully trained and supported in discharging her responsibilities in a clinically based service.
  - 2.11 Expedite plans to move the trust to a fully electronic recording system within a clear timescale in order to facilitate effective information sharing with other agencies to optimise the safeguarding of children and young people.
  - 2.12 Ensure that young people have good access to a range of opportunities to feedback on their experiences of the service and to inform and influence service development.
- 3. Sandwell and West Birmingham CCG should:**
- 3.1 With NHS England Birmingham, Solihull and the Black Country Area Team work with General Practitioners to ensure participation in child protection conferences whenever possible and the routine submission of GP reports to best inform child protection conference decision making.
  - 3.2 With NHS England Birmingham, Solihull and the Black Country Area Team work with General Practitioners to ensure all health information known about a looked-after child informs initial and review health assessments.
  - 3.3 Work with Sandwell Borough Council to ensure parental health history informs looked-after children's initial health assessments, subsequent health reviews and health histories for care leavers.
  - 3.4 Ensure that initial health assessment documentation is comprehensive and fully reflective of the individuality and voice of the child.

- 3.5 Ensure that care leavers receive comprehensive health histories/passports as they leave care and that their health needs are well supported as they enter adulthood.
  - 3.6 Ensure that the annual safeguarding and looked-after children's health report and action plan set out measurable objectives and timescales against which progress across the health economy can be measured effectively.
  - 3.7 Work with Public Health and Sandwell Borough Council to ensure that provider agencies have good access to multi-agency training and development on topics including female genital mutilation and child sexual exploitation.
  - 3.8 With NHS England Birmingham, Solihull and the Black Country Area Team, ensure that all GP safeguarding leads are engaged with the GP safeguarding forum on a regular basis.
  - 3.9 Ensure there is a robust quality assurance process in place for all initial health assessments including those undertaken by clinicians external to Sandwell when looked-after children are placed out of area.
  - 3.10 Ensure that GPs safeguarding practice is well supported through an established and robust process of regular supervision and annual appraisal.
  - 3.11 Establish a safeguarding named professionals' forum under the leadership of the designated nurse to support continuous improvement in safeguarding practice across the health economy.
  - 3.12 With NHS England Birmingham, Solihull and the Black Country Area Team work with General Practitioners to ensure that health visitor attendance at GP practice meetings is consistent and routine across the borough to ensure effective communication of the identification of vulnerabilities and facilitate the provision of early help support.
- 4. Cranstoun, Integrating Recovery in Service (IRIS) should;**
- 4.1 Identify an appropriately qualified and experienced safeguarding lead within the service to ensure effective engagement with local children's safeguarding arrangements and robust safeguarding practice within the organisation.
  - 4.2 Ensure that Think Family practice is embedded across the adult substance misuse service and that practitioners demonstrate that they routinely prioritise the safety of children in their everyday work and case recording.
  - 4.3 Ensure that practitioners routinely participate in discharge planning meetings as appropriate to ensure parents with new-borns are fully supported and discharge plans are comprehensive and robust.

- 4.4 Ensure that practitioners liaise routinely with health visitors and other disciplines in all cases where there is multi-agency support to vulnerable families or where there is a child known to be at risk.
  - 4.5 Ensure that referrals to MASH are concise, avoiding the use of clinical language and set out the risks of actual harm to the child or young person clearly to best inform decision making about the level of intervention required.
  - 4.6 Ensure that where a child in need or child protection plan is in place, that the current plan is on the case record and the practitioner has established a more detailed service agreement with their adult client to underpin this plan.
  - 4.7 Ensure that there is a current and robust DNA policy in place and that practitioners demonstrate compliance.
  - 4.8 Ensure that practitioners undertake children's safeguarding training at a level commensurate with their roles and responsibilities including multi-agency training at level three in full compliance with statutory guidance as set out in *Working Together 2013*.
- 5. Sandwell and West Birmingham CCG and Birmingham Community Healthcare Trust should;**
- 5.1 Ensure that health plans developed from initial and review health assessments are SMART with measurable objectives and timescales to facilitate ensuring that all looked-after children's health needs are met.

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## Next steps

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An action plan addressing the recommendations above is required from Sandwell and West Birmingham CCG within **20 working days** of receipt of this report.

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