

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

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

Date of review:	29 th September 2014 – 3 rd October 2014
Date of publication:	5 th February 2015
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Provider services included:	Heart of England NHS FT Birmingham Children's Hospital NHS FT Birmingham Community Healthcare NHS trust Birmingham Women's NHS FT Birmingham and Solihull Mental Health NHS FT University Hospitals Birmingham NHS FT Sandwell and West Birmingham Hospitals Trust
CCGs included:	Birmingham Cross City CCG Birmingham South Central CCG Sandwell and West Birmingham CCG (as commissioners of Sandwell and West Birmingham Hospitals NHS Trust only)
NHS England area:	Midlands and East Region
CQC region:	Central West Area
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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 Birmingham. 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 Birmingham, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 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.

How we carried out the review

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

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

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

In total, we took into account the experiences of 143 children and young people.

Context of the review

Most of Birmingham residents, 57.6% (671,344 residents) are registered with GP practices that are part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). 20.4% (237,400) of Birmingham residents are registered with GP practices that are part of the NHS Birmingham South and Central CCG and 18.1% (210,594) of residents are registered with GP practices that are part of the NHS Sandwell and West Birmingham CCG.

Children and young people make up 28.7% of Birmingham's population with 64.1% of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in Birmingham is generally mixed when compared to the England average. The infant mortality rate is significantly worse than the English average and the child mortality rate in Birmingham is comparable to the England average.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly worse when compared against the England average. Despite having a large proportion of looked after children within the area, the percentage of these children having up to date immunisations is significantly better than the England average.

Child and Maternal health data reports that in 2013, the overall percentage of all Birmingham'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 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. However, the rate of hospital admissions caused by injuries for children under 14 years of age was comparable to the England average, and the rate of hospital admissions for young people between the age of 15 and 24 years was significantly better when compared to the England average.

The rate of hospital admissions for mental health conditions was also significantly better than the England average and the rate of hospital admissions as a result of self-harm in 2012/13 was comparable to the England average.

In 2011, the conception rate for under 18 year olds per 1000 females in Birmingham was significantly higher when compared to the England average. Conversely, the percentage of teenage mothers in 2012/13 was comparable to the English average. Breastfeeding indicators are mixed; breastfeeding initiation was significantly worse when compared to England however, breast feeding prevalence at 6-8 weeks after birth is comparable to the England average.

In 2013, the DfE reported that Birmingham had 1395 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 94.6% of these children received their annual health assessments. This percentage is much higher than the England average of 87.3%. The percentage of looked after children that had their teeth checked by a dentist in Birmingham (93.9%), was much higher than the England average of 82.0%. As at 31 March 2013, there were 310 looked after children who were aged five or younger, the DfE reported that all of these looked after children had up to date development assessments.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Birmingham. The average score per child in 2013 was 13.6. This DfE score is considered to be normal. The average score has shown a small increase since the previous year, however over the last two years the average score has generally been consistent.

Commissioning and planning of most health services for children are carried out by Birmingham Cross City and Birmingham South Central CCGs.

Commissioning arrangements for looked-after children's health are the responsibility of the CCG and the looked-after children's health team, designated roles and operational looked-after children's nurses, are provided by Birmingham Community Health Care Trust, with Designated Nurses employed by Birmingham South Central CCG.

Acute hospital services are provided by Birmingham Children's Hospital, Heart of England Foundation Trust, University Hospitals Birmingham Foundation Trust and Sandwell and West Birmingham Hospitals Trust .

School nurse services are commissioned by Birmingham Local Authority Public Health and provided by Birmingham Community Health Care Trust.

Contraception and sexual health services (CASH) are commissioned by Birmingham Local Authority Public Health and provided by University Hospital Birmingham NHS FT, Heart of England Foundation Trust and a range of voluntary sector organisations.

Child substance misuse services are commissioned by Birmingham Local Authority and provided by Aquarius.

Adult substance misuse services are commissioned by Birmingham Local Authority Public Health and provided by Birmingham & Solihull Mental Health Trust and 28 voluntary sector organisations.

Child and Adolescent Mental Health Services (CAMHS) are provided by Birmingham Children's Hospital.

Specialist facilities are provided by Birmingham Children's Hospital.

Adult mental health services are provided by Birmingham and Solihull Mental Health Trust.

The last inspection of health services for Birmingham's children took place in 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from young people accessing services:

"It is helpful for me to be here as I feel safe. I don't feel safe outside."

"I am able to talk to my friends using the unit's phone but I want to be able to go to college so that I don't fall behind. The school is meant to be sorting this out but I haven't heard back yet."

"If this service in the youth centre wasn't here, all the girls would be pregnant".

"It is useful coming here. XXX (Nurse advisor) gives good advice and is easy to talk to."

"I can't believe I have been coming here for years. I just come in sometimes to chat and hang out."

"I first started accessing services when I was 13 and first time I got through to CAMHS I was offered CBT which I have had 5 or 6 times because the NHS only offer 6 sessions and I need about twelve. They have actually seen me more times than if they had given me the help the first time round."

"About a year ago I went to see my GP because things are getting difficult for me again and she agreed to make a referral to an adult mental health services because children's cut off at 16. I called up a week later and the referral hadn't been done. I gave another week, still hadn't been done. I was then phoning frequently and I became frustrated and went into the practice to make a complaint and lo and behold the referral was made. The frustration was making me feel more and more alone, feeling hopeless and helpless. I got an apology from the doctor but that doesn't change things."

We heard from parents of service users:

"The Queen Elizabeth Medical Centre was very supportive when our child was very unwell."

"It is lovely at Ashfield. We are always made to feel welcome and it is just what is wanted. We can visit at any time and the staff always make time for us. We are kept well informed about how our daughter is doing. We are also now being offered support by the GP, which hasn't happened before but is very welcome."

Support from CAMHS hasn't always been helpful. This is particularly when practitioners can change so quickly. Our daughter is autistic and changes of staff upsets her. "

“It is hard to find mental health beds for children. We kept being told she was too young at 16 years old.”

“She was discharged home with Home Treatment Team coming in. it was every day to start with but quickly reduced as she said she was alright, although she wasn’t really. We thought the support would be for a couple of months but it was withdrawn after three weeks”.

“Our daughter is supposed to have support from the youth support service but we haven’t heard from them since she became an in-patient”.

“Health services have helped quite a bit. CAMHS have been very supportive. The psychologist has done a lot of work with him on anger management and he has calmed down a lot. She has also helped me; I’ve learnt to handle it better.”

“The psychologist is easy to get hold of for advice and guidance, if we leave a message, she always gets back to us quickly. She is really supportive and will always get him into an early appointment or cancellation if we need it.”

“Changes of practitioners are disruptive. That’s unhelpful and difficult for a young person with ADHD to deal with.”

“Things are better at home and better with his siblings. He is coping with his anger better and uses strategies to calm down. I didn’t think they would work, but they have. He has matured under CAMHS.”

Foster carers told us:

“We always take the children to the same clinic for their medicals. They always see all the children at the same time and that makes things so much easier.”

“We have lots of dealings with the looked-after children’s Nurse. The kids love her. She doesn’t treat them like looked-after children, as if they are different. She is brilliant. When we have dealt with other members of the looked-after children’s nurse team, they have all been good.”

“The looked-after children’s nurse will come and see any of the children at home so that they don’t have to miss any school. That’s really important to our eldest as she is doing her exams and can’t afford to miss school.”

“We try to do three health training courses a year. They are interesting, on topics like ADHD, autism and that sort of thing and we get to meet other carers.”

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 Most women booking their pregnancy are referred through their GP. The referral form used by GPs in some parts of the city does not provide sufficient detail on the expectant's mother social history or vulnerability and this means that sometimes the opportunity to identify and offer support to a vulnerable woman is either lost or delayed. (**Recommendation 1.1**)

1.2 The use of the electronic patient record "badger net" (currently used in City hospital and due to be implemented imminently in Good Hope Hospital) effectively supports the confidential recording of important issues such as domestic violence, previous social care involvement, details of children in the household or children who may have been removed from the mother in the past. There is good compliance with recording of partner details and also the biological father if this is different.

1.3 At Birmingham Women's Hospital a decision has been taken to implement an alternative standalone electronic patient record system rather than badger.net. This may impede information exchange between maternity providers across the city. Women in Birmingham can opt to deliver at any one of the city's hospitals as part of the city "maternity choice pilot". Community midwives across Birmingham frequently care for women in the ante and post natal period that have delivered their babies in different hospitals, therefore the use of a different IT system could lead to a risk that comprehensive information sharing about the needs of unborns and newborns is lost, and is confusing for women who are part of the pilot as they may have to re-tell their history to staff in different settings. (**Recommendation 5.1**)

1.4 Most providers in midwifery and other health staff across the patch are not routinely using chronologies. Lack of chronologies is a common feature in serious case reviews, as they identify drift in care planning and are useful when transferring cases to other professionals, teams or outside of area. Some staff have told us they found completion of chronologies for the purpose of our review very useful as they could see drift in cases that would otherwise not have been evident to them. (**Recommendation 1.2**)

1.5 All Midwifery services have a “did not attend” (DNA) policy to identify, and a protocol in place to respond to women who do not attend ante natal appointments. and we saw how this was effectively implemented. Any midwife identifying two consecutive DNA ante natal appointment makes a request for a community midwife to call at the woman’s home and report back to the team. Although we saw compliance with the policy, feedback from the community midwife on any failed home visits was insufficiently robust and in some cases, meant a delay in information being obtained by the ante-natal team in a timely way to facilitate a referral to children’s social care.

1.6 All midwifery services visited have policies in place for expectant women to be seen alone at some point in the pregnancy. However if a partner attends appointments, the opportunity to see the woman alone and have a confidential discussion about sensitive issues is reduced. Routine enquiry regarding domestic violence is made at initial booking but cases sampled highlighted this was not repeated throughout the pregnancy. It is recognised that domestic violence can increase in pregnancy and this means that the opportunity for some women to disclose domestic violence to their midwife may be missed. (**Recommendation 1.3**)

1.7 Expectant teenagers are able to access the local “4U” group which is a series of parent craft classes supported by multi-agency involvement and is popular with the young parents. There are close relationships between the teenage pregnancy midwives and the Birmingham Family Nurse Partnership (FNP) to identify and refer those expectant teenagers who would benefit from this intensive support. We heard how the family nurse partnership works effectively to support those vulnerable young parents; however, although new teams are being set up across the city, there is often limited capacity for new referrals in the south. (**Recommendation 14.1**)

1.8 We have seen some innovative practice within universal services across the city. The launch of the Health Visitor “app” is an effective way to communicate and inform parents of services on offer. This is based on the healthy child programme and is available for both iPhone and android phones. It provides information for all parents, outlines what they can expect at appointments and highlights health promotion information. As these phones have the capability to translate the information, it can be used in different languages across all communities.

1.9 The Health Visitor led “ who’s in charge” programme is also a unique way to heighten parents’ awareness of the impact of alcohol on their ability to care for their child. All new parents are invited to attend a workshop that demonstrates the safeguarding risks to children if the responsible adult is under the influence of alcohol.

1.10 While there were some good examples of joint working and information sharing across agencies, there was a notable absence of face to face health visitor liaison with midwifery services. Communication and information exchange is limited to the use of maternity liaison forms which are used to highlight vulnerabilities. Health visiting staff we met with reported that this was an area of concern and reported difficulties trying to establish contact at times with midwives, in order to share information in a timely manner. Staff reported one incident when they visited a home to congratulate a mother on birth of her child and discovered the child had been taken into care at birth. The health visiting team were trying to find their own way to manage the situation and one team leader has introduced her own system whereby she emails all the midwives in the local cluster each week to request updates and information sharing. There is a significant risk that new mothers and babies are not being supported effectively due to the lack of liaison.
(Recommendation 2.11)

1.11 Engagement and information sharing between health visitors and GPs was robust and there was good evidence of joint working to support children and families. Quarterly meetings are held with GPs and there is a communication book at each practice. We saw case examples of families who were new to the area and about whom there were safeguarding concerns. The GP raised these concerns and liaised with the health visitor who made contact with family and referred onto the school nurse to ensure the older siblings were supported.

1.12 Within Family Nurse Partnership (FNP), cases reviewed showed good engagement and support for young people. Staff were responding appropriately whenever risks were identified and making referrals to the multi-agency safeguarding hub (MASH) as necessary. All staff in the team have been trained in the use and completion of Common Assessment Framework (CAF) processes to ensure families' needs are addressed.

1.13 FNP staff expressed some frustrations with the child protection process citing delays in safeguarding referrals being processed. Their biggest concern was delays in cases being allocated to a named social worker. In one case a five week delay was reported to have occurred. Health staff are not making best use of agreed escalation policies to highlight their concerns and to ensure children's and young people's needs are being met quickly and effectively.

1.14 In school nursing, the annual school health profile is helping to ensure health input is well targeted following analysis of local community needs. We heard of one school where the school nurses are providing training on female genital mutilation (FGM) to school staff to raise their awareness of risks to young people attending the school and support available as it is particularly prevalent in the locality.

1.15 Initiatives such as the “vulnerable girls group” and teenage health drop in run by school nurses at a local youth centre are contributing to keeping children and young people safe. They ensure girls who have been identified as at risk of self-harm and low self-esteem have access to support at an early stage. The girls are identified by school staff and a weekly session covering safety, emotional health and wellbeing are covered over a 12 week period. Both these initiatives provide invaluable support and opportunities for young people to link with health from an early stage.

1.16 We heard the teenage health drop in was previously held in five locations across the city however this has recently been reduced to one area. Young people who regularly used the service told us they have been coming for years and one young person told us “*me and my friends would’ve ended up pregnant if this wasn’t here*”.

1.17 Effective liaison and support to families is being hampered by non-attendance by school nurses at GP practice safeguarding liaison meetings, Cases sampled highlighted significant gaps in information sharing with limited opportunities for discussion of vulnerable families with children of school age. This is an area of significant development to ensure all risks have been identified and that a co-ordinated approach is in place to fully support children and young people’s needs. (**Recommendation 2.1**)

1.18 At times, school nurses seemed to have an “information movement” role and this is impacting on their capacity to provide direct clinical input. Their current remit includes responding to requests for children’s immunisation information for the domestic violence screening team, in addition to providing GP’s with alerts of children who are placed on child in need plans on behalf of the local authority. CQC inspectors were impressed with the establishment of a domestic violence keyworker within the school nursing team however at present the historic expectation to distribute clerical information is preventing them undertaking other clinical duties to support young people with health interventions. (**Recommendation 2.2**)

1.19 There are significant differences in emergency department (ED) arrangements across the city. We saw inconsistency in provision of documentation and subsequent completion of safeguarding triage questions and risk assessment tools at City, Heartlands, Good Hope Hospitals and Queen Elizabeth Medical Centre, meaning that these trusts cannot assure themselves that all safeguarding risks have been fully considered and that children and young people’s needs are being met. (**Recommendation 10.2**)

1.20 Some IT systems, particularly at Heartlands and City hospitals, do not readily assist with up to date flagging of children and young people at risk. This reduces the practitioner’s ability to undertake a comprehensive risk assessment and ensure all safeguarding concerns have been considered. (**Recommendation 9.1**)

1.21 Assessment documentation used at Queen Elizabeth Medical Centre for both adults and children is the same. This places a reliance on the practitioners to consider and record in free text all hidden harm issues when assessing an adult; Without the benefit of documentation that sets out key trigger questions to guide the practitioner in undertaking effective and comprehensive risk assessment, any hidden risks to children may not be identified. The assessment documentation does not comply with NICE guidance in relation to the assessment of risks to children as there are no mandatory fields for this. (**Recommendation 7.1**)

1.22 At Good Hope Hospital (GHH), reception staff obtain the demographic details of children and young people attending the ED, including the next of kin and details of who is accompanying them if this is different. This allows practitioners to ensure that appropriate consent is being obtained. Electronic flags are on the patient record to indicate if there is social care involvement or if the ED practitioner/team has made a referral to children's social care.

1.23 Children and young people attending the GHH ED may be seen by nurse practitioners, the GP providing primary care support or ED medical practitioners. It is the responsibility of the practitioner carrying out the first assessment to include the safeguarding assessment. This is not routinely being recorded for those children and young people who are seen by primary care or by the nurse practitioner. This means that for those children the assessment is less robust and an opportunity to identify and respond to a safeguarding or child protection concern is missed. (**Recommendation 4.1**)

1.24 At GHH, 16 year olds are assessed and treated in the ED's adult environment and adult paperwork is used. This means that a less robust assessment is made of their safeguarding needs as the prompts in the paperwork do not facilitate practitioners to consider their vulnerability as a child, rather than as an adult. (**Recommendation 4.2**)

1.25 Children and young people attending the ED at Birmingham Children's Hospital are safeguarded well. The new ED record at Birmingham Children's Hospital is an excellent example of triage for safeguarding and child protection. The new forms, which were completed consistently in cases sampled, requires ED practitioners to not only consider the requirement as laid out in the NICE guidance for the under 5s but also specifically requires an assessment for vulnerability for all young people over 10 years old.

1.26 Across sites, the identification and recording of children in households of adults who attend ED with risk taking behaviours or mental health concerns is not being routinely collected and recorded. The existing paperwork does not promote and support practitioners with this assessment. We saw many incidents of adults attending following self-harm or substance misuse where none of the agencies assessing the adult, including adult mental health services, had taken the opportunity to ask about children and record their findings. When a practitioner had identified children in the household, this often consisted of the most basic details. The lack of comprehensive risk assessment means there is limited consideration of impact of parental health on children and young people and the support needed to ensure they are safeguarded to achieve best outcomes. (**Recommendation 10.1**)

1.27 In most ED's visited, the environment was appropriate and conducive to keeping children and young people safe with appropriately skilled staff in place. However there are significant differences in the provision of facilities for example: a well-resourced dedicated paediatric waiting area within ED at City hospital, where nursing staff have a clear and open view of the area so that they can monitor young people there. In contrast the receptionists at the Queen Elizabeth Medical Centre have a restricted view of the waiting area, although there is CCTV coverage. The children's play room is not observable by staff in the department and this does increase the risks to children who may be in the room without parental supervision. There is no notification to parents to inform them of the need to supervise children's use of the room. (**Recommendation 7.2**)

1.28 Paediatric liaison across all ED's except Queen Elizabeth Medical Centre (QEMC), is carried out by a team of paediatric liaison health visitors employed by Birmingham Community Healthcare Trust who attend the department on a daily basis and review all attendances. While there is no paediatric liaison health visitor role at QEMC, there is some work going on in the trust to explore the potential for this role with the community healthcare trust. Currently the QEMC safeguarding team is automatically notified of all under 18 year old presentations at ED as they receive copies of the attendance treatment notes. This provides the safeguarding team with the opportunity to review all under 18 attendances to ensure all vulnerabilities and safeguarding risks have been identified.

1.29 Across sites we have seen good recording of ethnicity and religion and this promotes staff awareness when treating children and young people to ensure that they remain culturally sensitive and access translation services if necessary. Practitioners within both Birmingham Children's Hospital and the QEMC have a good awareness of the language needs of attending patients in a highly diverse population. Good use is made of Language Line and other translation and interpreting services. At QEMC, mobile PCs are to be introduced to provide instant interpretation. This will reduce any delay in children having their health assessed and commencing treatment.

1.30 Staff at Heartlands ED expressed some concerns about children's and young people's access to mental health services, particularly following a presentation of self-harm. Children are regularly being admitted to the department with self-harm and there can be delays getting CAMHS assessments, particularly at weekends. (**Recommendation 3.1**)

1.31 There are inconsistencies in the support available for young people who attend the Emergency departments across the city following episodes of substance misuse. At Birmingham Children's Hospital (BCH), the incidence of young people attending following alcohol or substance misuse is low, however, staff we met with were unclear of the referral route for these patients to access the local young people's alcohol and substance misuse service. Instead there is a reliance on paediatric liaison and notification to the school nurse for follow up. This could mean the opportunity for early support is missed. In contrast at Good Hope Hospital (GHH), young people can easily be referred directly to the local support service, Aquarius, as they have a base on site.

1.32 We saw how ED staff at both BCH and GHH followed up on any child or young person who left the department without being treated. Guidance is available to support staff in their decision making and on one file we read, there were clear notes on the patient record detailing the action taken by the senior nurse. We saw evidence on another case whereby the practitioner had diligently followed up with the parent to ensure the safety and wellbeing of the child.

1.33 Children and young people accessing contraception and sexual health services (CASH) across Birmingham are safeguarded well. At initial consultation CASH practitioners complete a questionnaire where many areas are compulsory for completion before the e-form can be closed. Questions asked include partner details, does the young person and/or the practitioner consider them to be at risk, what their living arrangements are etc.

1.34 The CASH service provision within Birmingham is flexible in the way that services are provided according to service user requirements. In one instance a well-established and very busy clinic is open seven days per week in a large, multi-national chain store and another is held in a youth centre within a notably deprived area of the city. Schools with high teenage conception rates are also targeted for sexual health promotion. We also saw that Heart of England Foundation Trust (HEFT) practitioners visit areas of the city that are known to attract hard to reach groups such as bars and night clubs so as to promote the services they provide. This is good practice in meeting the needs of a large and varied community.

1.35 Children and young people can self-refer to CASH services across Birmingham and all services provide 'drop in' provision. Service user information obtained has resulted in a flexible, multi-cultural service across Birmingham that promotes children and young people to seek advice and help at the earliest opportunity. Both CASH services provided by HEFT and University Hospitals Birmingham (UHB) make use of internet sites to inform children and young people of the services that are provided to them and how to go about accessing them at various, readily accessible sites across Birmingham. Campaigns have been undertaken using other social media to target hard to reach groups including gay men, black African people and young people to encourage them to attend for sexual health checks.

1.36 Following the CCGs' incentivisation programme, GP practices we visited regularly hold safeguarding meetings with the health visitor and midwife at which vulnerable families are discussed. The meetings are minuted, though these discussions are not routinely entered onto the patient record in all practices. At one practice we visited, the GP kept a database of children discussed at the meetings and individual health records were amended accordingly with actions clearly recorded. This is seen as good practice in helping to protect potentially vulnerable young people, especially those who might remain at the periphery of child protection measures.

1.37 There is scope for the Birmingham CrossCity CCG GP safeguarding champions to facilitate GP practices in developing a consistent approach in their safeguarding meetings. Arrangements work well for adults and for children under 5, however, there is no mechanism in place to elicit the contribution of school nurses for those children and young people over five.

1.38 Similarly, the arrangements to review the primary records of adults and children registering with GP practices is not consistently identifying vulnerability. Whilst there are established arrangements in place for a health review for those children under 5 who register with a GP practice, there is nothing comparable for school age children.

1.39 One GP we spoke with told us that liaison with health visitors was good but that it was less achievable with school nurses. They related this to capacity issues within the school nursing team. Although school nurses would respond to information requests from the GP they did not attend safeguarding meetings held at the practice. Health visitors did, however, routinely attend these meetings where individual cases would be discussed and information shared. Another GP we met with also advised us that they had limited contact with midwifery but where children and young people were under the remit of the family nurse partnership (FNP) that they were served well. FNP practitioners were reported to have more routine contact and information sharing with the GP to ensure a more co-ordinated approach to supporting vulnerable families.

1.40 GPs are routinely advised of attendances at ED of children and young people. However, the information contained on those notifications is often brief and does not always highlight that the young person is the subject of child protection measures or that a referral had been made to children's social services. One GP we spoke with advised us that when limited information was received she would routinely contact the ED to request full notes of consultations that took place. It was by doing this that she has previously discovered that the young person was already the subject of child protection measures and this would then prompt her to invite the young person to the surgery for further review. By not routinely advising GPs of the cause of injury or that children and young people are the subject of child protection measures or that a referral had been made, there is a risk that the GP might not be made aware of other health professional concerns and so be unable to act accordingly to assist in the protection of vulnerable young people.

(Recommendation 11.1)

1.41 Although GP practitioners we met with were fully aware of the benefits of early help in respect to supporting young people's mental health needs they told us they often experienced delays in getting assessments completed. Access to mental health services was reported to be a challenge with a significant number of CAMHS referrals reported to be referred back to the GP and people waiting at least a month for referrals and assessments to be processed. Adult mental health assessment was considered to be better as there was a single point of access which aids accessibility.

1.42 GP records we reviewed showed that the practice was receiving police notifications of cases of domestic violence however in many cases, the information received was several months old . An example of this was a report of an incident in June 2014 advising that children were present at the time and the notification was not received by the GP practice until September. Staff reported that they routinely ask to see patients following receipt of these reports however the delayed reporting can sometimes mean it is too late to provide the appropriate support that may have been needed.

One GP we spoke with showed us evidence of delays in receiving police notification of domestic violence incidents. Reports can take up to eight weeks to arrive following the incident taking place. In one case examined, we saw that on receiving a domestic violence notification the GP made contact and following a consultation, the patient disclosed that the domestic violence incident had actually taken place sometime before the GP received the notification and that following the incident she and her children moved to another area of the country. She had returned only after being assured that a similar incident would not take place and that the perpetrator of the violence was seeking help for an addiction. The GP saw this delayed notification and subsequent follow up as a missed opportunity to assure herself of the safety of the mother and her children at the earliest opportunity.

1.43 Within Adult Substance misuse services, robust arrangements are in place to ensure any risks to children and young people are identified as part of the assessment process. Assessments included information about the household, any children in the household or whom the adult may have contact with and the involvement of other agencies. Where children were in the household, information was provided about the safe handling and storage of medication such as methadone to ensure children's safety. Where risks were identified appropriate action was taken by staff and referrals made to children's services. Records reviewed showed that there was a process of ongoing risk management which enabled action to be taken by workers as early as possible to follow up any additional support needs or safeguarding concerns for children and young people.

2. Children in need

2.1 There are dedicated midwifery services for women with FGM across providers. We saw some innovative practice and consultation with local communities, including work with a local Somalian Women's Group, on how best to support women disclosing FGM and the development of pictorial bookmarks to help women explain to practitioners the extent of their injury. Midwives told us that where FGM was disclosed, a "cause for concern" form would be generated and shared with the woman's GP and health visitor. However limited consideration was given to information sharing with school nursing if the woman has other female children of school age as a precautionary measure.

2.2 Arrangements vary across the city in terms of access to a specialist midwife for vulnerable women. The availability of either specialist practitioners or clinics ensure women are able to access the additional support they need with enhanced visits. We have seen some robust collaborative working between midwifery and other services such as substance misuse, including a very low threshold for women to be able to access targeted support to manage their pregnancy within a specialist substance misuse clinic.

2.3 Expectant women with additional vulnerability or medical need are well supported at City Hospital. There are a range of specialist clinics, including a peri natal mental health clinic for women with complex needs alongside a psychological wellbeing clinic that is midwife led for women with trauma or who have been subjected to domestic violence.

2.4 Women who are booking their delivery at Good Hope Hospital with an identified vulnerability because of age, domestic violence, peri natal mental health or substance misuse, have good support to access specialist midwives, enhanced visiting and the option to attend specialist ante natal clinics. An individualised care pathway is negotiated looking at how, where and when ante natal care will be provided which supports expectant mothers to fully engage in the ante natal care phase and the needs of their unborn baby. We saw many examples of a person centred approach to midwifery care, including one to one guided tours of the delivery suite and women writing their own care plans to help alleviate anxiety.

2.5 Expectant mothers with additional needs are well supported at Birmingham Women's Hospital. Women who have a learning disability or pregnant teenagers can be provided with a specially developed set of maternity notes called "My Maternity Book". This booklet is designed to be used alongside the standard hand held notes to promote understanding and involvement by the woman in her own care and the needs of the unborn and new born baby.

2.6 Birth plans and CAFs are in place to aid staff to support vulnerable expectant mothers, identifying who needs to be informed about the delivery of the baby and any specific action to take place. However, plans we reviewed were often generic, not goal orientated, or completed and shared with the expectant mother. This is a missed opportunity to involve the woman and also to support midwives on the delivery suite and post natal wards to better understand the woman's needs and how to identify and address any relapse. (**Recommendation 1.4**)

2.7 Within school nursing, we saw evidence of high levels of input and activity to support children and young people. However intervention plans seen lacked obvious coherence and clarity of purpose, with no clear aim of intervention. It is therefore difficult to measure when children, young people and practitioners have achieved success. (**Recommendation 2.3**)

2.8 Arrangements for young people who present across the city with mental health needs are variable, and depend on whether the hospital site has a paediatric ward. We saw and heard that access to CAMHS is an issue for some ED departments (apart from at Birmingham Children's Hospital), and that the Rapid Assessment Discharge team (RAID) team is highly valued in the contribution they can make to assessment and advice to staff in the acute setting. However there is a significant risk that some young people are particularly vulnerable if there is no access to these services, and we did see cases where young people were held in ED overnight without appropriate assessment of needs or support whilst an inpatient bed was found for them. We are aware that during the time of our review, discussions were taking place to facilitate an enhanced emergency response assessment service for young people who attend Heart of England NHS Foundation trust sites.

2.9 Children and young people attending Birmingham Children's Hospital ED with mental health concerns or self-harm are treated and assessed promptly by CAMHS. The young people are admitted to the paediatric ward and once medically stable the CAMHS team visit and carry out their assessment. The arrangements for CAMHS to visit and assess out of hours has improved with the introduction of the Emergency Response Team who now provide weekend cover on some sites. They have been successful in expediting early assessment for young people with mental health issues, facilitating their engagement with an appropriate service quickly.

2.10 CAMHS operate a weekly referral meeting to consider young people who may need in-patient care. The Home Treatment Team attend this meeting and by completing joint visits with the clinical nurse specialist, can assess a young person's needs. This helps to ensure the most appropriate level of intervention is provided

2.11 When young people who may have been victims of child sexual exploitation (CSE) are ready for discharge from CAMHS services, referrals can be made to the SPACE project, operated by Barnados, who offer specialised support and counselling on a longer term basis. This ensures young people continue to be supported as their needs are decreasing.

2.12 We heard about and saw case examples where children and young people were benefitting from the therapeutic intervention and relationship with CAMHS practitioners. Parents with children supported by CAMHS spoke positively about the support their children and themselves received from the Ashfield in-patient unit. Another parent told us that mental health practitioners working with their family were accessible by phone in times of crisis for advice and guidance and ensuring children experiencing crisis were given priority appointments as necessary.

2.13 Some parents told us that while Home Treatment had been helpful to their child, the service had been withdrawn earlier than had been expected and before they felt the young person's mental health had fully stabilised.

2.14 CAMHS is developing a stronger approach to enabling young people to inform and evaluate CAMHS service delivery. A new young person focused evaluation process is being launched in January.

2.15 Birmingham Children's Hospital ED and CAMHS have worked closely with some young people and their families to produce individual care pathways for those who seek the support of ED on a frequent basis. This helps to provide a co-ordinated and consistent approach to young people at crisis points.

2.16 There is a perception amongst health professionals and service users that CAMHS access is difficult with high thresholds and lengthy wait times. This was variable in the cases we sampled. A 0-25 pathway is currently under development and it is anticipated this will meet an identified service provision gap and reduce waiting times.

2.17 The co-location of Aquarius children and young people's drug and alcohol workers with a CAMHS dual trained psychiatrist and clinical nurse lead is beneficial for children and young people. Immediate case discussion and regular case review for all young people aged up to 18 is available between the two disciplines. CAMHS workers at Aquarius will accept any referral for assessment, including verbal referrals, and will routinely undertake a first assessment on the same day according to risk. The aim at first assessment is to engage with the young person to encourage them to attend for a second, more in-depth assessment as necessary. Aquarius services are also promoting easy referrals to their services to negate the need for 'form filling' and associated waiting lists. This promotes health interaction with vulnerable young people.

2.18 At initial assessment Aquarius CAMHS practitioners will complete a strengths and weaknesses questionnaire (SDQ). Scores collated from the assessment are then used to inform interactions with children and young people which include further assessment of mental health needs including ADHD and post-traumatic stress disorder (PTSD).

2.19 Aquarius CAMHS practitioners working with children and young people undertake an initial risk assessment from which a plan of action is developed. We saw that the resultant plans are clearly defined with set goals, time limits and actions for practitioners to follow. We also examined evidence which demonstrated that risk assessments are routinely updated every two months or sooner should the young person's needs change.

2.20 The Aquarius adult services team currently employ drug and alcohol outreach professionals at all four Birmingham hospitals. "Think family" is well embedded and where adults are identified as using drug and/or alcohol questions are routinely asked of them about parental/carer responsibilities so that appropriate referrals can be made. In cases examined we saw that case workers are routinely identifying potentially vulnerable children and young people in the care of adult clients. Information regarding these young people is clearly recorded and includes full names and date of birth details.

2.21 Within the adult mental health team, Think Family is a new concept however we did see evidence of Think Family principles being included within the assessment proforma. This prompted practitioners to identify children with whom the adult patient has contact rather than only those for whom the patient has parental responsibility.

2.22 The adult substance misuse team records reviewed as part of dip sampling were of a good quality and sufficiently detailed to evidence the assessment of risk, intervention by staff and liaison with other agencies. Where any risk had been identified staff ensured these were managed in a responsive and supportive way. Records showed that in cases where safeguarding referrals had been made and no feedback had been received, staff had actively followed up cases.

We saw a good example of staff taking prompt action when concerns were identified about a service user. A grandparent attended the substance misuse clinic to collect a prescription and staff became concerned about their presentation and wellbeing, especially as they stated they were going home to care for their 5 month old grandchild. A referral was made to the MASH immediately, clearly stating the potential impact on the infant. No response was received despite persistent attempts to follow up therefore 5 days later another referral was made and this was escalated to ensure the family received support and the baby was safeguarded.

2.23 We reviewed a number of referrals made to the MASH by practitioners in EDs. While we saw evidence of good risk assessment undertaken by ED clinicians in the clinical notes scanned into the electronic record system, the safeguarding referrals made as a result of concerns being identified in ED were of poor quality. The risk of harm to the child was not set out sufficiently clearly. In one case, while a mother's disclosure of domestic violence by her partner was recorded in the clinical record, this was not included in the referral to MASH. In another referral, the information given about the care arrangements of a vulnerable infant were inaccurately stated on the referral, although correct in the clinical record.
(Recommendation 1.5)

2.24 Following trend analysis from MASH referrals received from Birmingham Children's Hospital, additional electronic prompts have been embedded into the Inter Agency Referral Form (IARF) in conjunction with the lead child protection ED consultant, trust child protection professionals and the city wide hospital/MASH social worker team manager. This has driven up the quality of referrals from this site. Despite poor referral quality being a common theme across all providers, these additional prompts have not been rolled out across the city.

This case demonstrated how the Aquarius adult service team identified two children in the care of a mother who was abusing alcohol. The case worker identified that there was a significant risk to the two young children and their older sibling and after discussion with a line manager a referral was made to children's social services. The referral was made with the mother's consent. A children and young person's practitioner made joint visits to the family home with the mother's alcohol practitioner to further assess the children's vulnerability and in the meantime all of the children were made the subject of child in need measures. Despite the older sibling not abusing drugs and alcohol we saw that the Aquarius children's practitioner continued to offer them support regarding their mother's addiction, to the point where, despite them all remaining children in need, the whole family are making good progress and are to be transferred to the care of the Aquarius family team for continued support at a lower level as the risks are reducing.

3. Child protection

3.1 Arrangements are in place at Good Hope Hospital to distribute, and respond to, requests for midwifery attendance at child protection (CP) conferences. However, these can often be received with minimum notice and although we saw evidence of reports being submitted for conference, these were not being made routinely available to the conference chairs. The trust is not in a position to assure itself on the numbers of child protection conferences attended by midwives or on the quality or submission of reports. (**Recommendation 4.3**)

3.2 Invitations for midwives from City Hospital to attend child protection conferences are received by the named midwife who then negotiates with teams as to who will attend. There is an expectation that a report will be completed prior to the date of the conference and that this will have been shared with the expectant mother. However, this is not happening routinely and the current system for monitoring is not sufficiently robust. We saw evidence of midwives either attending conference without preparing a report or not attending and not submitting a report, thus losing the unique contribution of midwifery as part of the child protection decision making process. (**Recommendation 8.1**)

3.3 Midwives we spoke to told us of ongoing delays with initial child protection conference (ICPC) meetings and subsequent development of birth plans resulting in new mothers and their babies experiencing extended stays on the post natal ward and this is not good practice. We saw some evidence of health staff highlighting this on individual cases, however there is a lack of formal escalation being used effectively, despite the presence of appropriate protocols across agencies.

3.4 Midwives are not always exploiting opportunities outside of the formal child protection forums to share information on vulnerable families. We saw some evidence of good information sharing between health and children's social care, however, there was also an over-reliance on formal meetings to share information in some cases which meant a delay in responding to concern. For example, in one case seen at City Hospital, the expectant mother had not declared openly about her level of substance misuse and the midwife waited until the ICPC to make contact with the named substance misuse worker at which point significant vulnerabilities were highlighted.

3.5 Adequate arrangements are in place at Birmingham Women's Hospital to monitor invitations to child protection conferences through the safeguarding team's bespoke database. The expectation is for all conference reports to be submitted prior to conference and for these to be shared with families. In files we reviewed, there was good evidence that midwives were attending conferences and core groups and diligently making notes as a record whilst they waited for the formal minutes to be sent.

The peri-natal mental health service is supporting mothers to be and new mothers with mental health problems well and we saw a good practice case example with positive outcomes for mother and new baby who continue to do well with support.

We saw a case example in a community mental health team demonstrating effective partnership working between the mother's social worker, specialist peri-natal mental health midwife, health visitor and the CMHT practitioner. Following the unborn baby being placed on a child protection plan, an extended five day stay in maternity and assessment for mother and baby unit, mother is doing well and has been able to return home from maternity ward. An intensive support plan agreed with mother is in place whereby the mother will receive a daily visit from one of the professionals involved for the first two weeks at home to ensure her needs and those of her new baby are being met.

3.6 There was evidence that health visiting staff were taking appropriate action where safeguarding risks were identified. Staff in the team did however report that there was some variation in the quality of information sharing with children's services. Records seen showed health visitors were supported to attend CP meetings and core groups and demonstrated good levels of attendance and engagement. This included undertaking joint visits with social workers to contribute to assessment and monitoring of parental compliance with CP plans.

3.7 School nurses are well engaged with formal CP arrangements. The expectation that a senior practitioner will attend all ICPCs and then follow up with a comprehensive health assessment and risk assessment, ensures children's needs are being addressed. Following this assessment, a clinical decision on the contribution that the school nurse can make determines further attendance at meetings. This ensures the service can maximise its value and target resources to those children and young people who are most in need.

3.8 Health visitor and school nurse liaison is strong and develops a community of practice around families who are accessing input from both services. The mandatory face to face handover for children and young people on CIN or CP plans ensures all practitioners are aware of needs.

3.9 We examined some referrals to children's care from ED practitioners and these were of variable quality. Whilst we recognise the challenges in completing a comprehensive assessment of risk in a busy ED, the quality of these requires review across sites. Referrals did not include sufficient detail about the nature and circumstance of the incident prompting the child's attendance for emergency treatment. Referrals did not fully articulate the clinicians' concerns about the risk of harm to the child, the reason for the referral or expectation as to outcome.
(Recommendation 1.5)

3.10 Practitioners in the ED routinely telephone the MASH to discuss their concerns, although responses to telephone calls are reported to be slow. No record is kept of these conversations in the patient notes and there is an over reliance by practitioners on the detail of their concern having been covered in the conversation rather than subsequently setting this out clearly in the written referral. This is a key area for development.**(Recommendation 11.2)**

3.11 As a common theme across health disciplines, staff we spoke to were clear on the referral process to the MASH, however less sure on what to expect in terms of outcomes of this. This limits their ability to challenge when the agreed process for safeguarding children doesn't seem to be working to achieve best outcomes.

3.12 Lists of children and young people currently subject to child protection measures in Birmingham are not available to practitioners across all EDs. ED staff at Birmingham Children's Hospital, are alerted to children and young people with social care involvement by the presence of an electronic flag. This ensures that important information is shared quickly with the child's social worker. Lists of children and young people currently subject to child protection measures in Birmingham are not available to practitioners within QEMC, City hospital or Virgin Health Minor injury units. If it becomes apparent during consultation that a young person is subject to a child protection plan, this is flagged on IT systems for future reference but reliance is placed on staff members to ascertain this at triage. This could mean that young people who are subject to a plan or a child in need who do not disclose are not recognised as vulnerable within the departments.

3.13 At Birmingham Children's Hospital, where child protection or safeguarding concerns have been identified in the ED, referrals are made to the MASH through the electronic inter agency referral form. Embedded e-prompts are contained within the form to guide practitioners in how to make a good and informative referral. The referral form also contains a CSE assessment tool which looks at risk and vulnerability and is a useful tool to guide practitioners in their analysis of risk.

3.14 Although there is not a missing child policy operating across the QEMC, staff routinely record the appearance and clothing of children attending ED for treatment. If a child leaves or is taken from the ED by parents before being seen by a clinician, or before treatment is completed, practitioners routinely follow this up by taking a number of actions. This could include contacting the parents, contacting the children's hospital to see if the child has been taken there and contacting the police to request a welfare check. This is good practice to safeguard the child's health and wellbeing.

3.15 QEMC are developing a database on which to store information on missing children and adults. This is intended to support effective identification of missing people should they present for hospital treatment.

3.16 CASH practitioners formally assess risk via a comprehensive assessment at initial consultation. The completion of an electronic questionnaire including partner details, whether the young person and/or the practitioner consider them to be at risk, what their living arrangements are etc. has compulsory fields which must be populated before the form can be closed. Practitioners then seek advice regarding making a referral via the MASH.

3.17 CASH practitioners employed by HEFT and UHB are aware of how to refer cases of concern across Birmingham via the MASH. We examined several written referrals in HEFT which generally contained an adequate amount of information but did not always fully articulate actual or perceived risk to young people and could be more robust in the way that they are presented. In contrast, referrals from UHB services were of good quality and clearly highlighted potential risk to children and young people. (**Recommendation 4.4**)

3.18 Whilst undertaking our review we witnessed evidence of health practitioners from CASH at UHB seeking advice from their safeguarding lead regarding clients that were currently being seen in clinic. In one instance we saw that risks had been noted by a practitioner during initial consultation which included the seventeen year old person having disclosed multiple partners all older than her, consuming alcohol with older men, being introduced to older strangers and having been the subject of a previous sexual assault. It was decided at an early stage in the consultation that a referral to children's social care via the MASH would be appropriate in this case, and the practitioner was advised to call practitioners at the MASH prior to the referral being made to confirm. This is good practice in providing help to a vulnerable young person and providing support and re-assurance to staff members in their actions.

3.19 CASH and Aquarius drug and alcohol case workers practitioners across Birmingham are not routinely invited to advise or attend initial child protection conferences (ICPC) or other relevant child protection meetings. This is a missed opportunity to obtain information from professionals who often develop close working relationships with children and young people who often lead chaotic lifestyles. We did see evidence of CASH practitioners 'chasing' the results of ICPC meetings so as to inform themselves of the current child protection status of their clients.

Cases reviewed demonstrate Aquarius young people substance misuse service support workers clearly consider the risks associated with CSE across Birmingham and will take appropriate action when those risks are identified. In one case, the case worker, on developing a good working relationship with the young person, began to suspect that she was involved in a relationship with an older male. The young person was already known to social services and was in care. The Aquarius case worker made a call to social services regarding their concerns but at the time it was considered that the young person did not require further interventions. At a later review meeting, the mother of the young person disclosed how she had obtained evidence of the young person, who was now resident in a children's home, having developed internet relationships with several older men. With this in mind the Aquarius case worker again made a referral to children's social services and an emergency CSE meeting was planned shortly after our review taking place.

3.20 A Barnados CSE worker is seconded to work with the Aquarius service and this is a positive development. Although new in post it is planned that the worker will provide awareness training in both multi-disciplinary and multi-agency settings to promote this important area of child protection. Senior practitioners within Aquarius have also undertaken a four day CSE awareness training provided by Barnados with the aim of cascading their knowledge to other practitioners. A CSE screening tool to be used at initial consultation is currently being developed for practitioners to use.

3.21 Adult drug and alcohol workers are routinely identifying potentially vulnerable children and young people in the care of adult clients. Information regarding these young people is clearly recorded and includes full names and date of birth details. Workers are generally invited to attend child protection case conferences and will prioritise attendance or supply written reports where necessary. We were told that they are also routinely advised of the outcomes of child protection meetings so that their own records can be updated accordingly.

The specialist child protection nurse for CAMHS told us about the positive impact of the MASH and the improved response to referrals. We heard how a referral had been considered about a 15 year old female who was in a violent relationship with an 18 year old male. The initial response had been to provide the family with some information about domestic violence and local support. However, because of multi-agency involvement at the outset a strategy meeting had taken place, with input from police and health, and a decision was taken to support a Section 47 assessment. This was a positive message to the girl and her family that local services recognised the impact of domestic violence.

3.22 There are place of safety, section 136 mental health act assessment facilities located at the CAMHS in-patient unit. The 136 pathway is reported to be established and working well for highly vulnerable young people.

3.23 CAMHS referrals to MASH routinely describe clearly the events and issues leading up to the referral. However, they do not always set out the risk of harm to the child sufficiently and it is not always clear what the purpose of the referral is. They could be further strengthened by explicitly stating risk of harm to the child and health's expectation of children's social care response. (**Recommendation 3.2**)

3.24 There is an expectation that CAMHS practitioners are part of core groups and attend child protection conferences, submitting written reports if they cannot attend. Managers and practitioners told us that invitations to conferences are sometimes received late and therefore staff are unable to attend. There is a responsibility on health practitioners to ensure that they are aware of dates for conferences as these should be planned well in advance.

3.25 There is a rigorous "was not brought" policy in CAMHS. Non-attendance at appointments are followed up routinely to ascertain reasons and a letter is sent within seven days to parents, copied to the referrer, and the GP to ensure all relevant people are aware of any concerns.

3.26 We saw some good engagement with CP processes in primary care. One GP we spoke with advised us that she was routinely invited to advise or attend initial child protection conferences or review meetings and that following those meetings she would receive minutes of the meetings which were scanned and then placed onto patient records. In other cases, it was evident that GPs were invited to case conferences, however there was no information to show that minutes were received when the GP could not attend.

3.27 Some GP records reviewed showed that while there was a commitment from the practice to promote child safeguarding, gaps in information sharing across agencies were preventing this being effective in terms of managing risk. In one case, records indicated the GP had been informed by the social worker about an incidence of domestic violence and that an assessment was pending. There was no further evidence that the social worker updated the practice of the outcome or that the GP practice followed up the issue for clarification.

3.28 GPs we visited demonstrated a very proactive approach to safeguarding with evidence that any risks were being highlighted and that appropriate steps were taken to ensure those risk were managed and appropriate intervention takes place. There were arrangements for flagging alerts where safeguarding concerns were apparent and to identify children who are looked after. Where concerns related to a family, alerts were flagged across the family's records. GPs were actively reviewing information about hospital attendances and following up issues of concern.

3.29 Information sharing between the Multi Agency Risk Assessment Conference (MARAC) and primary care is not robust. Coding of families is not established. This means that the GP may not be fully informed of any risk or vulnerability around domestic violence when in consultation with their patient.

Case eg: The GP in this case demonstrated good personal involvement in developing relationships with the mother and grandmother of the child who is subject to child protection measures following domestic violence. Having been made aware of the child being made the subject of a child protection plan the GP tried to encourage the mother to attend the surgery with the child for routine health assessments. When this did not work the GP visited the mother and child at home and has since built up a good working relationship with her, even undertaking medical examinations of the mother and child there. Information is shared with the grandmother of the child (who has legal responsibility for her) and the mother is being encouraged to attend the GPs surgery so that over reliance on the GPs visits to her home does not take place. The GP has informed child protection meetings about her involvement and we examined evidence of the minutes of those meetings being scanned and placed on both the child and the mothers electronic medical records. This is seen as good practice

4 Looked after children

4.1 There is good identification of ethnicity, religion and language on looked-after children documentation sent to health by children's social care. This is essential information to inform the delivery of health support in the most appropriate and effective way.

4.2 Most initial health assessments (IHA) reviewed contained good birth history of the child and at least some information about parental health history. In several cases, the health history information related to both parents and was comprehensive. This is positive practice as it is essential that this information is gathered and conveyed to health so that it can follow the child's journey through care. Most looked-after child documentation also set out the legal status of the child and the reason they became looked after.

4.3 Initial Health Assessments (IHA) and Review Health Assessment's (RHA) we sampled were variable in quality, we saw some excellent examples and others which required development. These inconsistencies spanned across both the LAC nursing and paediatrician teams undertaking the assessments. There is no quality assurance process in place therefore there is no mechanism for the designated doctor and nurse to drive up the quality of the assessments and subsequent plans. (**Recommendation 2.4**)

4.4 RHAs are episodic in nature and do not routinely link to the previous health assessment to ensure that all health needs identified previously have been met or updated. (**Recommendation 2.5**)

4.5 A very small number of IHAs are undertaken by the LAC nurses. If a young person declines to meet with the paediatrician or is hard to reach, there is documented discussion between the looked-after children nurse team and the paediatrician. The paediatrician reviews the assessment and health plan in discussion with the looked-after child nurse who undertook the IHA. This is recognised to be practice by exception only to ensure the young person has their health needs identified, as this is not compliant with guidance.

4.6 Health plans seen were not SMART. They are task focused with loose timescales, and do not always set out clearly who is responsible for ensuring the identified health need is met. In a number of cases reviewed it was unclear why some actions had been included in the health plan as these issues were not identified on the assessment documentation. For example a young person was recorded as needing a referral to CAMHS “asap” on the plan but there was no reference to mental health needs throughout the assessment.

(Recommendation 2.6)

4.7 In both IHAs and RHA’s, we saw limited evidence of the personality or voice of the child and it was often a list of descriptive information that had been provided by accompanying adults, with no observational information recorded. We saw little evidence of young people being given the opportunity to engage directly with the assessment process such as signing their own consent to having their health assessed or information on their health being shared across agencies. This is a missed opportunity to encourage young people to engage with managing their own health. **(Recommendations 2.7 and 2.8)**

4.8 Some IHA and RHAs reviewed were completed outside of expected timescales. In most cases, notification of the young people becoming looked after was not prompt, introducing delay at the start of the process. While the statutory responsibility to ensure child’s health needs are met does lie with children’s social care, we did see one case where the child’s health needs were not reviewed for over a year and this had not been identified by the LAC health team. Recently, a named worker in each CSC base has been identified to be responsible for prompting social workers in the team to complete and send paperwork to the LAC health team to facilitate greater efficiency and ensure children’s health needs are assessed more promptly. This will help address the issue of delays.

4.9 Health visitors had a good knowledge of children who were looked after and actively engage with the LAC team to ensure the health needs of children placed out of area were supported.

4.10 There is good use of both the strengths and difficulties questionnaires (SDQs) and WEMWEBS assessment for emotional wellbeing in the IHAs and RHAs. Young people are encouraged to complete a self-assessment SDQ to facilitate monitoring and recognition of their own emotional growth. In one RHA we reviewed, the clinician referred to the outcome from the SDQ in the assessment documentation, giving consideration to the implications related to the child’s emotional health needs and future support needed.

4.11 CAMHs provide ongoing support to young people and foster parents where placements are fragile and we heard about case examples where placements had been sustained through this provision. Although there is no dedicated CAMHS service for children who are looked after, those requiring CAMHS support are prioritised for appointments when they are referred. The CAMHS advice and guidance phone line provides good opportunities for professionals, foster parents and parents concerned about their own children's emotional wellbeing to discuss issues with a specialist. However, CAMHS do not routinely input information into RHAs or IHAs when they are working with the child. Managers acknowledge this is an area for development. (**Recommendation 3.3**)

4.12 There is a Dialectical behaviour therapy group for foster carers run by CAMHS practitioners, which has been established at the request of foster carers and is well regarded. It aims to develop their skill and knowledge base to enable them to support children with challenging behaviours and intense emotions more effectively.

4.13 Health support to care leavers is underdeveloped. The care leavers receive a letter setting out some health history and immunisations however, it is very clinical in presentation; it is not attractive to young people and does not act as an effective health passport. Although young people are provided with the looked-after child health team phone number to contact should they want further help or advice, the team does not have capacity to provide active ongoing support on a regular basis. (**Recommendation 2.9**)

4.14 There is a disconnect between primary care and the needs of LAC. This has been identified as an area for development by the named GP's however current capacity and the CCG focus on embedding safeguarding arrangements mean this has not yet moved forward. GP's we met with were open to learning and keen to engage however unclear as to the expectations and differing health needs of children who are looked after, particularly those in residential settings. Whilst health visitor and school nurse records are reviewed to assist with information gathering prior to RHA's, GPs in Birmingham are not routinely being asked to contribute to initial health assessments and review health assessments. This is a gap and means that the assessments may not reflect the full health needs and care of these children and young people. (**Recommendation 2.10**)

4.15 We have seen evidence of the focus on improvement in the looked after children's health team, in terms of achieving statutory timescales and data sets, however this has been at the expense of service development, delivery and health access work by the looked after children's nurses, particularly to the residential homes. The enthusiasm of the designated nurse has meant some innovative practice has developed, including the use of a "Quick response" (QR) barcode for young people to scan and view a RHA appointment on YouTube to help them understand the appointment and facilitate their attendance.

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 Safeguarding within primary care across Birmingham is well led. Safeguarding champions have been identified in Cross City CCG and each GP practice has a safeguarding lead. Quarterly meetings take place to support practice leads in safeguarding practice and regular newsletters and updates are provided by the CCG.

5.1.2 We have seen some strong examples of GP engagement with safeguarding. As seen in other disciplines, the interface with both social care and other health providers in the city is rugged and there is a lack of comprehensive information sharing. Due to the incomplete nature of information exchange, without clear accountability or follow up action planning; there is a risk of either duplication of actions or no follow up as practitioners are operating under the assumption that others are actioning safeguarding concerns about the child.

5.1.3 The named GP's have currently limited capacity to drive forward innovation due to SCR commitments, however have a sound oversight of the needs of the city as a whole and the strategy needed moving forward. The recent development of "master classes" to top up Level 3 GP training is an integral part of this.

5.1.4 The designated nurses within both CCG's have developed some innovative arrangements to drive up the quality and engagement of a number of partner and providers. Examples include the provider safeguarding assurance visits, CQUIN for safeguarding and the use of 3 month pilot projects on different themes. In some areas, we have seen a strong culture of auditing and piloting new ways of working, to provide an evidence base to develop updated service models across the city and strengthen safeguarding practice.

5.1.5 The CCG designated nurses for safeguarding are providing supervision to the safeguarding teams across providers and meet with the provider safeguarding lead on a monthly basis, alongside being part of the providers safeguarding committee arrangements. Their input is valued by the teams we met, who feel that while the CCG's expectations of improved safeguarding performance by the trust is clear, and the designated nurses are providing effective practical support to facilitate improved performance.

5.1.6 The impact of the recent implementation of the MASH is beginning to filter through to some services and professionals we met with were optimistic of the impact of the new arrangements over the medium to long term and the opportunities it provides. However we saw and heard of many cases where the processes in place are not yet fully translating to changes and positive outcomes for young people. This includes delays in picking up calls both in the MASH and subsequently in the safeguarding hubs, and a lack of communication on outcomes and actions from the MASH to referrers. Cases seen highlighted the need for health staff to “push” for answers and outcome on cases, and in some cases, repeated referrals being submitted. Staff are not using escalation policies effectively in these cases, and we saw a lack of clarity in expected processes following referrals being made. This leads to health practitioners being less equipped to challenge what should have happened as they are unsure of this. We saw an opportunity for some health providers to be invited to “walk the floor” in MASH to ensure they are fully engaged with the process and this is a positive tool to aid practitioner’s engagement and support. The City wide Hospital/MASH social worker team manager acts as a link with health providers and has completed some useful work with one provider (BCH) around the use of prompts on the electronic referral form to help staff provide the correct information and drive up the quality of referrals. This has not been rolled out to other providers despite similar issues being identified.

5.1.7 Capacity restraints within the MASH have resulted in health oversight on only those cases rated red at triage. However there is a significant need for amber cases to be reviewed and this is a missed opportunity to help in keeping children and young people safe and ensure the right services are in place quickly. This under representation of health in MASH is not only related to resources but also skill mix and there is a concern that practitioners with specialist knowledge such as in adult mental health and adult substance misuse are not yet involved. We are aware that during the course of our review there were ongoing meetings to discuss MASH resourcing and specification for the next commissioning window next year. However the success of MASH will depend on the needs and changes to be felt more rapidly across the city, and it may be difficult to sustain the current momentum if this is not addressed more quickly. (**Recommendation 12.1**)

5.1.8 Practitioners need to build their confidence in the MASH and its’ successful outcomes. There are also operational issues around how quickly information can get to the MASH and in cases where health referrals are not being made electronically (usually by fax to another Birmingham Council building) this can also impede prompt actions.

5.1.9 Escalation policies are in place and we have seen the use of this in some cases. We have met some confident and committed professionals who are persistent in their approach to ensuring children and young people’s needs are being met. However, often this was based on strong and long term interpersonal relationships and their sphere of influence rather than being underpinned by robust organisational relationships. The health economy in Birmingham is about more than one provider supporting all of Birmingham’s children. We have not seen a picture of children, young people and vulnerable families’ needs being met in a fully collaborative, co-ordinated and cohesive manner.

5.1.10 Historic fragmentation of health services has led to delays and significant gaps in collaborative working as each organisation maintains their own identity and develops processes within this. There is a lack of cohesion across the city leading to issues with equity of access and in differing service delivery models. The CCGs are beginning to work with providers on this. There is more to do to ensure effective information sharing and learning from best practice and service developments across the health economy. Current arrangements not conducive to driving services forward and ensuring children's needs are being met as effectively as they could be across the city.

5.1.11 Long standing practices have not been discontinued therefore as new initiatives come on stream this can lead to potential overload and confusion across teams. The speed and frequency of changes in service arrangements have not allowed for practice to be embedded and going forward, this is having an impact on practitioners level of engagement with new services and systems that aim to better meet children's needs. There has been no reflective review of what needs to continue nor permission to discontinue processes that are outdated or defunct. There is opportunity to make better use of current resources if this happens .

5.1.12 . Health visitor and school case records reviewed were of a good quality with detailed information about intervention and liaison with other agencies. Staff demonstrated persistence when raising concerns and following up referrals. The re-development of assessment paperwork based on the CAF format has had a positive impact on ensuring comprehensive assessments are undertaken and we saw some excellent planning with clear goals and outcomes in some cases . However, the use of generic templates for planning for children on CIN or CP plans is having a detrimental effect on the quality of plans for children who meet these thresholds

5.1.13 Health visitors working with corporate caseloads have established systems to ensure all children deemed as "in need or at risk" have a named health visitor. Tools are in place to ensure equity of caseloads and risk management. Learning from a serious case review has led to the establishment of quarterly caseload management days where caseloads are reviewed as a team to ensure all safeguarding risks have been identified.

5.1.14 The recent introduction of a bi-monthly "frontline reference group" by the Birmingham Safeguarding Children's Board aims to ensure practitioners across all agencies have a forum to highlight particular issues. It also allows the safeguarding board to hear the view of staff working directly with children and families. It is anticipated this will further develop a training matrix based around specific local need in future.

5.1.15 ED practitioners at BCH described the named nurse for safeguarding as being very visible. She attends the ED fortnightly and provides group supervision to the team, where patients of concern are discussed as well as quality of referrals and any missed opportunities identified through paediatric liaison. This helps to ensure a process of continuous quality improvement and ongoing learning. The named doctor for child protection has initiated a series of peer reviews within the ED to identify and discuss cases with safeguarding elements to promote ongoing learning about how best to protect children and young people.

5.1.16 Both CAMHS and Birmingham and Solihull mental health trust managers have set clear expectations that where both mental health services are involved with a family, that there will be direct liaison between practitioners and that both services will attend discharge planning meetings as required.

5.1.17 The Health Professionals Advisory Group (HPAG) meets bi-monthly to share common safeguarding issues and good practice. This is chaired by a designated doctor and involves all safeguarding named and lead nurses and doctors.

5.1.18 The Head of Safeguarding for Adults & Children is also the named midwife for Birmingham Women's Hospital, leading to capacity issues due to the portfolio of the role. This has been recognised by the trust and the safeguarding team has recently gone through reconfiguration. Two whole time equivalent safeguarding specialist safeguarding nurses have been recruited and interim arrangements are in place until they commence work with the trust.

5.1.19 Birmingham and Solihull Mental Health Foundation Trust report positive relationships with police who respond to issues or concerns raised by the adult mental health assertive outreach team via the Specific Point of access (SPOC) police officer. This ensures adults with mental health needs and their children and families are supported quickly should safeguarding issues arise.

5.1.20 Birmingham against FGM are now a part of the LSCB subgroup and are focusing on education of GPs and raising community awareness of FGM.

5.1.21 Individual and frontline staff are championing safeguarding but the lack of robust internal and external organisational processes underpinning this means there is an imbalance between high levels of input from practitioners and lower levels of positive outcome in some cases we reviewed.

5.2 Governance

5.2.1 Many providers told us about the recent introduction of the safeguarding CQUIN by commissioners. The requirement is for each organisation to identify good practice and share it across their teams and to include the voice of the child. We heard how even though this was still in its infancy, it has already had a positive impact in identifying and celebrating success amongst staff and teams.

5.2.2 The CCG has strengthened its approach to children's safeguarding over the past 18 months as there are now clear and explicit safeguarding expectations set out in the new contract arrangements. This includes all providers having regular safeguarding assurance visits carried out by the two designated nurses in both CCGs. The designated nurses are also part of each provider organisations safeguarding committees in order to provide supportive monitoring and steering to ensure safeguarding arrangements are continuously improved.

5.2.3 It is not clear that the designated nurse for looked-after children has sufficient capacity (one day per week) to undertake the full range of responsibilities and ensure effective governance under the current arrangements. In addition there is a potential conflict of interest due to her operational LAC nurse role. Having a commissioner and a provider role, there is a lack of clarity on how effective governance can be undertaken. (**Recommendation 12.2**)

5.2.4 Health visiting staff reported there were arrangements for auditing case records each quarter using a 10% sample. Information from audits was shared with respective practitioners and used to inform future practice.

5.2.5 Statistics on delivery of the healthy child programme by health visitors indicated 84% compliance for new birth contacts but improvement is needed with 2 and half year checks, which are currently 60% compliant. Service models are being reviewed to improve accessibility and the pilot 'play and stay' programme within children's centres with health visitor involvement has seen an increase in uptake in these checks.

5.2.6 Within FNP there was evidence of systems for auditing and reviewing records for safeguarding practice on a regular basis and using findings from audits to improve practice. This included dip sampling 10% of records within each caseload by the nurse supervisor. Information is then submitted to the safeguarding team and findings reported back to the team to aid further learning.

5.2.7 Concerns were raised about the review of paediatric liaison service and forthcoming pilot in one hospital. All teams report this is a valuable resource and one that they feel will create risks if removed. Input has often resulted in lessons learned which have been included in the risky business newsletter.

5.2.8 There was evidence that GPs were taking a proactive approach when reviewing notifications of hospital attendance but a lack of clarity within notifications meant that sometimes there was a risk of duplication of reporting. It was reported that notifications of hospital attendances are received but there were some frustrations around the information received depending on the provider. For example BCH will report attendances and state the number of times the child/young person has attended in the last 12 months. Where there have been multiple attendances they do not state if any action has been taken and therefore the GP follows this up. In a number of cases, follow up by other teams was also ongoing, leading to duplication and lack of clarity on who was taking the lead to ensure children and young people were appropriately safeguarded and supported.

5.2.9 Although practitioners at the Virgin Health MIU do not hold cases, all staff members are supported to make safeguarding referrals when they consider it necessary. Managerial oversight of referrals made is good with in-depth analysis of referrals made to ascertain if improvements could be made for the future and to highlight best practice.

5.2.10 There is no routine quality assurance of referrals made to MASH by the QEMC although referrals are copied to the trust's safeguarding team. Periodic audits are undertaken of referrals but these have not focused sufficiently on the quality of the referral, concentrating on ensuring staff have followed the referral procedure correctly.

5.2.11 The part-time named nurse for children's safeguarding in QEMC left the role during our review. The trust is increasing its investment in the safeguarding team by making this post full-time and increasing the administrative support to the role. This will facilitate a significantly increased focus on ensuring that safeguarding governance arrangements are strengthened. This demonstrates a positive commitment by the trust to an agenda of continuous improvement in safeguarding practice and performance.

5.2.12 Recording practice at QEMC is good. Although clinical notes are handwritten and scanned onto the electronic record, all records reviewed were written clearly, gave good detail of examinations and treatments with use of diagrams to indicate locations of injuries sustained by children. Clinicians routinely signed their assessments and clinical notes entries ensuring a good audit trail and effective accountability, should actions and decisions need a retrospective review.

5.2.13 Attendance cards at QEMC are signed off by a consultant at the point of discharge from the ED, however this sign off is clinically focused and does not include an overview that all safeguarding risks have been considered in the case. This would also be facilitated by a redesign of the pro-formas used to comply with NICE Guidance. (**Recommendation 7.3**)

5.2.14 Senior medical staff at Good Hope Hospital have now introduced random sampling of locum doctors work to enquire a consistent quality service to patients attending the ED. Safeguarding decision making is part of this review. This helps to ensure that vulnerable patients attending the ED are not disadvantaged by their care being provided by non-permanent staff.

5.2.15 Both Aquarius and CAMHS practitioners working with children and young people undertake an initial risk assessment from which a plan of action is developed. We saw that the resultant plans are clearly defined with set goals, time limits and actions for practitioners to follow. We also examined evidence which demonstrated that risk assessments are routinely updated every two months or sooner should the young person's needs change. CAMHS and Aquarius practitioners routinely meet to discuss cases, including newly referred cases at a meeting held every two weeks. This promotes peer review of case work and helps to identify risks that might otherwise be overlooked. Audits are routinely undertaken of these case files to ensure risk assessments and action plans are reviewed and updated according to policy.

5.2.16 The CQUIN target focused on driving partnership working across agencies is facilitating improved multi-agency work. Although this target is not always met, in the case we reviewed a multi-agency meeting was convened within four days. The CQUIN target has significantly driven improved timescales for multi-agency meetings and as a result, young people with complex needs are being responded to more promptly.

5.2.17 We heard about and saw case examples where children and young people were benefitting from the therapeutic intervention and relationship with CAMHS practitioners. This was not well evidenced in case records however. There is not a sufficiently strong and consistent approach to care planning and establishing child centred goals to steer and guide practitioners' work. It is difficult therefore for young people, practitioners and operational managers to track and monitor progress in case work through case recording. (**Recommendation 3.4**)

5.2.18 The use of a paper-based recording system in the CAMHS service does not facilitate effective and prompt information sharing and communication in a multi-agency partnership which is increasingly using electronic communication and recording systems. Case records in general in the service were poorly ordered and there was no evidence of effective record management or governance of case recording. In a service using paper records, practitioners may find it difficult to easily access key information and this can increase risks. (**Recommendation 3.5**)

5.2.19 Specific child protection paperwork in CAMHS case records alerts practitioners to safeguarding issues in the case and this documentation acts as a repository of summary information and a chronology for safeguarding issues affecting the young person. Managers and practitioners told us that this works well in alerting them to issues in the paper based recording system.

5.2.20 CAMHS is developing a stronger approach to enabling young people to inform and evaluate CAMHS service delivery. A new young person focused evaluation process is being launched in January 2015.

5.2.21 BCH have recently introduced a process whereby Inter Agency Referral Forms generated from the BCH ED team should be copied to the trust safeguarding team to facilitate the establishment of a quality assurance process to drive continuous improvement. However this is not yet being done routinely or consistently by all staff. (**Recommendation 3.6**)

5.2.22 University Hospitals Birmingham CASH service users are encouraged to take part in an annual survey of service provision in Birmingham. We examined information from the last survey undertaken by UHB CASH practitioners during November 2013. We saw that information provided by service users goes on to inform and change the way that services are provided which includes adapting to local area social changes in population to ensure services are targeted to meet needs.

5.2.23 In adult mental health services, child protection plans are not routinely secured onto the electronic client record due to trust policy. In one case we found that child protection plans for three siblings were being kept in the psychiatrist's desk drawer. This is not best practice and as this case example demonstrates, there is a significant risk that vital child protection plans which need to be immediately accessible to the case worker to guide detailed care planning and direct intervention, will be lost from the record. (**Recommendation 6.2**)

5.2.24 The Birmingham and Solihull Mental Health Foundation Trust has a policy in place to ensure the safety of children who visit parents & other significant family members who have been admitted to hospital, while facilitating the child's contact with parents or family members. The policy is overdue for review however and is based on national guidance which has been superseded. (**Recommendation 6.3**)

5.2.25 GP records sampled demonstrated that records were being coded appropriately to alert practitioners to vulnerability. This includes where children have child protection plans and also children who are looked after.

5.3 Training and supervision

5.3.1 Variations in level 3 training requirements and expectations across providers mean that in the majority of services visited, staff training is not compliant with intercollegiate guidance. This is particularly with reference to the multi-agency component. Only the named doctor in the QEMC ED has undertaken level three safeguarding training and in City hospital, historically, level 3 training has only been required for senior nurses. For FNP, health visitor and school nursing staff, level one and two training is mandatory for all staff with an in house bespoke top up to level three trust standards. CAMHS practitioners access some face to face training with an e-learning component to fulfil their level 3 requirements. These do not however meet the guidelines in terms of multi –agency training. (**Recommendation 13.1**)

5.3.2 Midwifery services at City have previously recognised the need for training and supervision to be strengthened as part of the earlier Sandwell CLAS review and are in the midst of effecting these changes.

5.3.3 Most providers have acknowledged that ensuring that practitioners and non-clinical staff across the trust undertake safeguarding training to levels commensurate with their roles and responsibilities is an area for ongoing development. Some have action plans in place to improve performance in this area and there has been a significant improvement in numbers of staff undertaking training since April 2014.

5.3.4 At BCH, appropriate arrangements are in place to ensure ED staff access Level 3 training. Although most ED practitioners attend the trust's in-house training, some do attend the update training delivered by the Birmingham Safeguarding Children's Board, including workshops on CSE. Throughout the summer, Birmingham Children's Hospital trust hold a series of study days, one of which is around safeguarding and is based on case studies to ensure staff's safeguarding knowledge and practice is continuously developing.

5.3.5 To reinforce good practice and to keep practitioners' awareness of children's safeguarding issues high, the QEMC holds monthly mandatory paediatric days for ED practitioners. Staff find this beneficial as a refresher on safeguarding practice and how to recognise the sick child.

5.3.6 With the exception of Aquarius young people substance misuse services, there is more to do across all providers to ensure supervision processes are consolidated, particularly with reference to recording. Discussions and actions are not routinely documented in case notes so that plans can be followed up easily. Providers cannot be assured that all safeguarding issues have been robustly followed up to ensure children's safety and wellbeing. (**Recommendation 13.2**)

5.3.7 Aside from Heartlands hospital and BCH, formal supervision arrangements across ED's are adhoc. Nursing staff within City hospital ED do not receive regular, structured safeguarding supervision. We were advised that staff members are encouraged to seek advice from senior staff when required, but that there is no formal format to this and any such discussion is not routinely recorded. There is no opportunity for ED staff to meet and discuss cases of concern, to learn from good practice, missed opportunities to refer to children's social care or on the quality of referrals. This means that there is no mechanism for driving quality in safeguarding children practice within this team. (**Recommendation 10.1**)

5.3.8 Staff at Heartlands we spoke with told us that they felt supported in their role and that peer support was very good. Arrangements in place for supervision as part of trust supervisory framework involves case specific supervision for staff in high risk areas. Within ED there were mechanisms for sharing good practice in safeguarding and changes in policies and procedures which included the distribution of a 'risky business' newsletter three times a year, used to feedback lessons learned across ED.

5.3.9 All practitioners working within CASH services who might have contact with children and young people are trained to level three safeguarding. The training is provided by multi-disciplinary staff members and includes modules regarding CSE and FGM.

5.3.10 Cash practitioners employed by HEFT receive monthly supervision on a subject of their choice which can include current project progress, personal managerial issues or safeguarding supervision. Although regular, routine safeguarding supervision is not provided we were advised that it is routine practice for practitioners to bring two to three safeguarding cases to supervision on a regular basis.

5.3.11 Cash practitioners employed by UHB receive safeguarding supervision via a peer group setting on a quarterly basis. Difficult and challenging cases are discussed with an oversight of 'what went well and what did not go so well.'

5.3.12 Where cases are discussed at supervision for both HEFT and UHB CASH services, the detail of cases discussed and tasks arising from supervision are not routinely recorded in service user notes. We are aware of re-commissioning arrangements currently underway in CASH services and that IT systems are relatively new. It is hoped that continued development of the IT system will allow for routine recording of safeguarding supervision discussions in the future.

5.3.13 All nurse practitioners at the Virgin Health minor injury unit are trained to safeguarding level three, although training is currently provided online due to the lack of face-to-face training availability. The provider is working closely with the Birmingham CCGs to provide appropriate training to staff in a multi-agency setting which will be more in line with the latest guidance.

5.3.14 Nurse practitioners within the minor injury unit are afforded regular, structured safeguarding supervision. This is conducted on a regular basis in groups with peer support and managerial oversight. Individual cases are discussed and learning is recorded accordingly. Safeguarding supervision is offered on a protected time basis.

5.3.15 Aquarius support workers and case workers are trained to at least level three safeguarding with training as provided by the LSCB. Managers are trained to at least level four. This is considered good practice and is in line with the latest guidance.

5.3.16 Safeguarding supervision is provided by a safeguarding lead at Aquarius on a monthly basis and this takes place in groups with peer support. Individual cases are discussed with outcomes of any such discussion clearly recorded on case notes with actions highlighted.

5.3.17 Senior practitioners within Aquarius have undertaken four day CSE awareness training as provided by Barnados with the aim of cascading their knowledge to other practitioners. A CSE screening tool to be used at initial consultation is currently being developed for practitioners to use.

5.3.18 CAMHS supervision is an area for development. Although practitioners have clinical and managerial supervision routinely, it is the responsibility of the practitioner to request safeguarding as part of the agenda, if they have any cases with identified child protection issues. This is not concordant with Working Together 2013 and not sufficient to facilitate practitioner continuous improvement in awareness and practice. (**Recommendation 3.7**)

5.3.19 Current arrangements for Birmingham Womens Hospital practitioners to receive supervision in safeguarding children are weak and have been identified as an area for development. The current policy means an over-reliance on the named midwife which is unsustainable. The trust has identified funding for external training and is developing new guidance to address this.

5.3.20 Robust arrangements are in place for staff in the community health teams to receive regular safeguarding supervision and support from the Birmingham Community Healthcare Trust named nurses. It was reported they try to ensure continuity with the named nurse for supervision for each practitioner to facilitate discussion and follow up on agreed actions.

5.3.21 One GP we spoke with advised us that she is supported well by the designated GP for safeguarding and that she receives regular safeguarding updates and advice. She explained that the named GP had recently attended her surgery to advise staff members on best practice and to share examples of what was working well in their own practice. She told us, *“There is always something going on in safeguarding every couple of months. We are kept well informed.”*

Recommendations

1. **Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust, Birmingham Women's NHS Foundation Trust and Sandwell and West Birmingham Hospitals NHS Trust should ensure that;**
 - 1.1 maternity referral notification paperwork is updated to include prompt questions on social history and vulnerabilities
 - 1.2 the use of chronologies is embedded across all services to prevent drift in cases
 - 1.3 routine enquiries about domestic violence are undertaken throughout pregnancy
 - 1.4 individual goal orientated birth plans are put in place within midwifery services, with SMART targets to ensure women's needs are better understood and supported
 - 1.5 referrals made to the MASH clearly identify and articulate risk and expected outcome

2. **Birmingham Cross City CCG and Birmingham South Central CCG with Birmingham Community Healthcare NHS foundation trust should ensure that;**
 - 2.1 school nurses routinely attend GP practice safeguarding meetings
 - 2.2 outdated processes with regard to information movement and notification by school nursing is reviewed to increase capacity to undertake clinical duties
 - 2.3 intervention plans formulated by school nurses are specific and outcome focused
 - 2.4 a quality assurance process is established to develop the quality of initial and review health assessments for children who are looked after
 - 2.5 information and actions contained in previous review health assessments is evaluated routinely as part of the review health assessment process
 - 2.6 the quality of health plans for children who are looked after is improved, including specific goals that are timely and have clear accountability

- 2.7 young people are given the opportunity to sign their own consent on documentation for initial and review health assessments
- 2.8 the voice of the child is included as a key component of all initial and review health assessments, with an emphasis placed on observational recording
- 2.9 support for care leavers is developed with the provision of more comprehensive and age appropriate health information
- 2.10 GPs are routinely asked to contribute to initial and review health assessments
- 2.11 robust arrangements for liaison and communication between health visitors and midwifery services are established

3. Birmingham Cross City CCG and Birmingham South Central CCG with Birmingham Children's Hospital NHS Foundation Trust should ensure that;

- 3.1 access to CAMHs assessment in Heartlands ED is reviewed for timeliness
- 3.2 processes are put in place to develop the quality of referrals made to the MASH from CAMHs practitioners
- 3.3 the CAMHs team have an opportunity to contribute to initial and review health assessments
- 3.4 intervention plans in CAMHs are developed with a clear outcome focus
- 3.5 record keeping in CAMHs is improved to ensure files are ordered and paper records are managed to ensure information can be easily located
- 3.6 copies of the inter agency referral forms sent to the MASH are routinely copied to the BCH safeguarding team as per trust quality assurance process.
- 3.7 formal safeguarding supervision arrangements are developed for the CAMHs team

4. Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust should ensure that;

- 4.1 safeguarding documentation in ED at Good Hope hospital is consistently completed as part of the initial assessment by all practitioners

- 4.2 the use of adult paperwork for young people aged 16-18 attending ED at Good Hope Hospital is reviewed to ensure all safeguarding risks have been considered
- 4.3 quality assurance processes are put in place to develop midwifery contribution and/or attendance at child protection conferences.
- 4.4 processes are put in place to develop the quality of referrals made from CASH services to the MASH to ensure risk to the young person is clearly articulated
- 5. Birmingham Cross City CCG and Birmingham South Central CCG and Birmingham Women's NHS Foundation Trust should ensure that;**
 - 5.1 robust arrangements for information sharing are established between maternity choice pilot sites
- 6. Birmingham Cross City CCG and Birmingham South Central CCG and Birmingham and Solihull Mental Health NHS Foundation Trust should ensure that;**
 - 6.1 child protection plans are secured with the client notes to ensure Practitioners can access them as part of intervention and future planning
 - 6.2 the safety policy for children visiting inpatient wards is updated in line with current national guidance
- 7. Birmingham Cross City CCG and Birmingham South Central CCG and University Hospitals Birmingham NHS Foundation Trust should ensure that;**
 - 7.1 ED documentation at Queen Elizabeth Medical Centre is reviewed to comply with NICE guidance
 - 7.2 supervision arrangements for the children's playroom are put in place
 - 7.3 discharge paperwork sign off in Queen Elizabeth Medical centre includes an oversight of safeguarding risk assessment
- 8. Birmingham Cross City CCG and Birmingham South Central CCG and Sandwell and West Birmingham Hospitals NHS Trust should ensure that**
 - 8.1 a quality assurance process is established for midwives' attendance or contribution to child protection conferences.

9. Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust and Sandwell and West Birmingham Hospitals NHS Trust should ensure that;

- 9.1 systems are developed to allow flagging of children and young people subject to child in need or child protection plans in ED

10. Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust, University Hospitals Birmingham NHS Foundation trust, and Sandwell and West Birmingham Hospitals NHS Trust should ensure that;

- 10.1 arrangements are put in place for formal safeguarding supervision within ED departments
- 10.2 safeguarding documentation and triage questions in emergency departments are consistently completed and assessed

11. Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust, Birmingham Children's Hospital NHS Foundation Trust, University Hospitals Birmingham NHS Foundation trust and Sandwell and West Birmingham Hospitals NHS Trust should ensure;

- 11.1 detailed notification information is sent to GPs following an ED attendance, including child protection status and appropriate follow up by health teams
- 11.2 safeguarding consultation calls between ED practitioners and the MASH are documented on ED paperwork.

12. Birmingham Cross City CCG and Birmingham South Central CCG should ensure that;

- 12.1 health resourcing for the MASH is considered with reference to capacity and specialist expertise
- 12.2 the role and capacity of the designated nurse for looked after children is defined to allow more robust governance of the looked after children health system

- 13. Birmingham Cross City CCG and Birmingham South Central CCG with Heart of England NHS Foundation Trust, Birmingham Women’s NHS Foundation Trust, Birmingham Children’s Hospital NHS Foundation Trust, University Hospitals Birmingham NHS Foundation trust and Sandwell and West Birmingham Hospitals NHS Trust should ensure that;**
- 13.1 level 3 training requirements for appropriate staff are developed in line with intercollegiate guidance
 - 13.2 safeguarding supervision is routinely documented in client notes to ensure robust follow up of actions
- 14. NHS England area team, working in partnership with Birmingham City Council and Birmingham Community Healthcare Trust should ensure that;**
- 14.1 access to Family Nurse Partnership in the south of the city is reviewed in terms of capacity

Next steps

An action plan addressing the recommendations above is required from Birmingham Cross city and South Central CCGs 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.