Review of Health Services for Children Looked After and Safeguarding in Rutland

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

Date of review:	22nd July - 26th July 2019
Date of publication:	4th October 2019
Name(s) of CQC inspector:	Sue Talbot Lee Carey Louise Holland Paula Morgan Lea Pickerill
Provider services included:	University Hospitals of Leicester NHS Trust Leicestershire Partnership NHS Trust Midlands Partnership NHS Foundation Trust Oakham Medical Practice Turning Point
CCGs included:	NHS Leicester, Leicestershire and Rutland Clinical Commissioning Groups
NHS England area:	Midlands region
CQC region:	Central region
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Dr Janet Williamson

Contents

Summary of the review **3**
About the review 3
How we carried out the review 4
Context of the review 4
The report 6

The child's journey **6**
Early help 6
Children in need 10
Child protection 15
Looked after children 18

Management **22**
Leadership & management 22
Governance 25
Training and supervision 27

Recommendations **30**

Next steps **33**

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Rutland. 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 the Clinical Commissioning Group (CCG) and Local Area Team (NHS England).

Where the findings relate to children and families in local authority areas other than Rutland, 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* (2018).
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information before and during the visit. This included document reviews, interviews 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 individual cases where there had been safeguarding concerns about children. This included some cases where children were recently referred to social care and others where children and families had not been referred but were assessed as needing early help from health services. We also sampled a spread of other such cases spanning universal and specialist health provision.

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

In total, we considered the experiences of 50 children and young people including 6 cases that we tracked involving the work of a wide range of health practitioners and partner agencies.

Context of the review

Rutland has a population of 39,700 people. This includes 7,685 children and young people under the age of 18 years (21.4% of the population). A total of 5.7% of the population are from a black or minority ethnic background.

Rutland has fewer areas of economic deprivation compared to most other local authorities in England. It is estimated that 4.6% of pupils attending nursery and primary schools and 4.7% of pupils attending secondary school in Rutland are eligible for and claiming free school meals. This compares with 13.7% of pupils attending nursery and primary schools and 12.4% of pupils attending secondary school in England as a whole.

The health of people in Rutland is generally better than the England average, with comparatively good life expectancy for both men and women. Infant mortality rates are comparatively low. Fewer children are classified as obese. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are better than the England average. Hospital admissions for mental health conditions or self-harm are relatively low.

Commissioning and planning of most health services for children are carried out by NHS Leicester City CCG on behalf of Leicestershire, Leicester and Rutland CCGs.

Commissioning arrangements for looked-after children's health are the responsibility of NHS Leicester City CCG. All specialist medical and nursing staff including the looked-after children's health team, designated doctor and operational looked-after children's nurses, are provided by Leicestershire Partnership NHS Trust (LPT).

Acute Hospital and maternity services for people from Rutland are mainly provided by University Hospitals of Leicester, Kettering General Hospital and North West Anglia NHS Trust. As part of the inspection University Hospitals of Leicester was visited.

Rutland's Minor Injuries Unit is run by nursing staff employed by Oakham Medical Practice.

Health visitor and school nursing services are commissioned by Leicestershire County Council Public Health and provided by LPT. The health visiting and school nursing team, known as the 'Healthy Together' service covers Melton district in Leicestershire as well as Rutland.

Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are also provided by LPT.

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

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

The number of children looked after by Rutland Council is relatively low compared to most other English councils. Approximately 38 in 10,000 children aged under 18 in Rutland are looked after, compared to 64 in 10,000 nationally.

A total of 30 children were in the care of the local authority at the time of the review. Only 4 children were placed locally within Rutland. The majority were placed in neighbouring councils and the wider region. The Strengths and Difficulties Questionnaire used to measure the emotional and behavioural health of children looked after indicates a similar score to the rest of England.

In July 2019, 79 children had a child in need plan. A total of 22 children were on a child protection plan.

This report takes into consideration the findings of previous inspections by CQC. The report also reviews evidence of improvements in practice and learning from local serious case and learning reviews.

The report

This report follows the child's journey and reflects the experiences of children and young people, parents and carers to whom we spoke; or whose experiences we tracked. Recommendations for improvement are made at the end of the report.

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 The emergency department (ED) at Leicester Royal Infirmary (LRI) children's hospital is welcoming and child-friendly. Children receive a prompt review of risks to their health and wellbeing. A qualified senior nurse carries out a visual assessment of all children before they are booked in by the department's clerk. Children are seen, assessed and supported to receive care in line with the most appropriate care pathway. ED practitioners are vigilant to risks presented by children with rapidly deteriorating conditions and those who do not wait to be seen.

1.2 Careful consideration has been given to tailoring the ED environment to best meet the specific needs of children with disabilities, including autism; and young people presenting in mental distress. A *'Changing Places'* toilet has been recently installed which promotes positive recognition of the personal care needs of people with disabilities and provides an accessible environment that promotes their dignity. These approaches positively recognise the diversity and vulnerability of children and young people attending ED.

1.3 Children and young people with mental health needs are promptly seen by the mental health triage team and are supported to remain in a suitable environment until their mental health or self-harming risks can be fully assessed. The ED facilities can be sensitively controlled to promote a calm and safe environment where children can be seen by the mental health crisis team 24 hours a day. This approach is effective in diverting children from needing to be admitted to the paediatric ward for ongoing care and treatment.

1.4 University Hospitals of Leicester NHS Trust (UHL) has strengthened its routine notification arrangements for children attending ED. The 0-19 Healthy Together public health teams, Children Looked After (CLA) health team and local GPs are notified within 24 hours of all attendances of children at Leicester Royal Infirmary. This denotes a significant improvement on the previous paper- based system used to share information with the 0-19 public health team. UHL has sought and received assurance that such automated notifications are appropriately logged on LPT's electronic case management system. These notifications in turn are reviewed by LPT's administration staff, and using guidance provided; they select those that need to be brought to the attention of health visitors. The effectiveness of these screening arrangements had not been reviewed at the time of this review.

1.5 During our visit to the ED at LRI, we identified gaps in promptly escalating concerns to partner agencies about harms to children, including for example, bruising to a toddler. CQC's previous Children Looked After and Safeguarding (CLAS) Review in Leicestershire (November 2018) highlighted shortfalls in the expected standards of practice in this area. In recent months, UHL has been working closely with LPT to agree criteria for an enhanced notification system. The new approach, which went live on 1st August, aimed to provide health visitors and school nurses with an additional alert to aid workload prioritisation and review of children's needs and family circumstances. Assurance is needed of the impact of the enhanced notification system in supporting effective recognition and timely management of risk as children move between services*. This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health services.* ***(Recommendation 6.1)***.

1.6 The 0-19 public health team was not always effectively informed about children attending other neighbouring councils' emergency departments. In one record, ED practitioners failed to notify the local team about a child with an injury who was previously on a child protection plan. The child left the department before a full examination and treatment had been offered. Further work was required to promote effective information-sharing and follow up of children moving between wider regional health services and localities. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health services.* ***(Recommendation 7.1)***.

1.7 Rutland's Minor Injuries Unit (MIU) staff had a clear focus on the provision of early help to prevent the need to travel to emergency departments located some distance away in Leicester, Kettering or Peterborough. Local arrangements also recognised the specific needs of people presenting with mental health difficulties. MIU staff were available to treat the physical injuries of people who self-harmed. GPs from the on-site medical practice could be called on to offer additional support where there were concerns about the wellbeing of children or adults. MIU practitioners can refer relevant children or adults for mental health assessments which they report usually takes place within 5 days. This helps ensure a timely and holistic response to individual needs.

1.8 The MIU staff notify the 0-19 and CLA health teams when any Rutland child or young person under 18 years of age accesses the service. If the young person lives outside Rutland, their named GP is informed. This meant relevant other agencies were made aware of children's attendance and any ongoing support they might need.

1.9 Health visitors undertake targeted work with Rutland's communities that has strengthened their visibility and support for children and families. This includes a link health visitor for military families living in the area. This approach recognises the challenges many such families with young children face; including the impact for them in moving home or having limited local networks of support. Good links have been established with relevant health practitioners in other areas of the UK and abroad to assist children's transitions and sharing of information about individual needs.

1.10 The 0-19 Healthy Together team employed a care navigator to assist families of children with complex needs or disabilities to access ongoing treatment and review of their health and development. In one record we reviewed, the care navigator effectively supported a mother with learning difficulties to attend multiple appointments for herself and her children. This ensured timely and effective oversight of the health care of all family members.

1.11 The community midwifery service offered good continuity of care. We spoke to one expectant mother who told us care provided by UHL's community midwives had been 'brilliant' and that there had been proactive exploration of her needs. She told us '*you can call the midwives whenever you're worried and they will see you straight away. The midwives have asked me questions to make sure I feel safe. They have included my partner at all times and asked him how he is feeling too'.*

1.12 UHL offered a good post-natal service to Rutland's women and their babies. Women can be visited for up to 28 days after birth and are offered a choice of home visits or clinic contact. This helped ensure good ongoing access to midwifery care at a time when the resilience and coping capacity of families may be stretched.

1.13 Health visitors were notified of all midwifery bookings, but only conducted targeted antenatal home visits to first time mothers or women with known vulnerabilities. This was a missed opportunity to identify home and family circumstances and routinely offer health promotion advice and support. *This was brought to the attention of the Director of Public Health as commissioner of health visiting services.*

1.14 The school nursing service in Rutland was highly visible to schools, families and young people. Good use was made of technology to provide timely and accessible support. This included electronic referral forms, social media presence, online questionnaires and apps for young people to access the service or request specific advice and support.

1.15 The school nursing service benefitted from having clear care pathways that actively promoted early help and the delivery of targeted support and interventions for emotional health. This included the offer of up to 4 sessions following referral, with additional support provided as required by the team's lead emotional health and wellbeing nurse.

Positive Practice in Rutland's School Nursing Offer

The lead emotional health and wellbeing school nurse provided a strong early help offer with evidence of positive outcomes from targeted work undertaken. The post holder also had an important role in identifying children and young people with undiagnosed conditions or developmental delay who would benefit from a neuro-developmental assessment. This specialist role was well-established, with evidence of its positive impact also noted in Rutland's Special Education Needs and Disabilities (SEND) inspection letter (2017).

Work undertaken by the school nursing service helped 'bridge the gap' between targeted and specialist child and adolescent mental health (CAMHS) provision and formed an essential link for children who may need additional support.

1.16 The Young Person's team (CAMHS) reported good joint working relationships with children's social care in Rutland. An early help meeting spanning operational staff from the City, County and Rutland enabled shared discussions of children who were due to be 'stepped down' from specialist CAMHS. This helped ensure their need for lower level ongoing support was recognised.

1.17 The Midlands Partnership NHS Foundation Trust (MPT) made good use of social media to promote awareness and encourage take up of its contraception and sexual health screening services. The approach encouraged greater understanding and self-management of sexual health needs and risks.

1.18 Integrated sexual health provision provided by MPT for children and adults in Rutland was limited. The local offer consisted of a three-hour sexual health clinic one evening a week for all age groups operating from Rutland Memorial hospital. Managers recognised the challenges of relying on a shared room that was used for other clinical purposes. This detracted from the provision of a 'young person friendly' environment as encouraged within '*You're Welcome'* quality criteria*.* Further review of local arrangements would assist in identifying levels of usage by young people, and of actions needed to address shortfalls in the use of current facilities. *This was also brought to the attention of the Director of Public Health as commissioner of the sexual health services.* ***(Recommendation 9.1)***.

1.19 MPT's sexual health practitioners provided sexual health training for LPT's school nurses in the provision of emergency contraception. The school nursing service included the provision of condoms via the C-card scheme and chlamydia testing. Such joint arrangements worked well in enabling young people to have options in how they accessed relevant information, advice and support.

2. Children in Need

2.1 Risks to children from abuse and neglect were appropriately considered within case records seen in Leicester Royal Infirmary's paediatric ED, including checks for non-accidental injury and whether children and families had a social worker. The use of a safeguarding checklist helped promote consistent practice in screening for risks of abuse or neglect.

2.2 Young people aged 16-17 years attending adult ED however, did not benefit from the same level of vigilance to risk. Shortfalls in safeguarding practice had been previously identified in the Leicestershire CLAS review which highlighted the need to strengthen identification of the vulnerabilities of adolescents presenting within the adult emergency care environment. In response, UHL had introduced a checklist to help strengthen professional curiosity about the circumstances and levels of risk young people may be exposed to. However, 19 out of 25 case records seen by inspectors of young people 16-17 years of age, did not have the safeguarding checklist completed. ***(Recommendation 8.1)***.

2.3 Adults attending ED were not routinely asked about their caring responsibilities for children. This had also been identified as an area of safeguarding practice to strengthen in the Leicestershire CLAS review. The electronic and paper record templates did not contain any prompts to ask about children or the support available to them whilst the adult/parent attended hospital. Arrangements did not support consistent practice in promoting adult practitioners' ongoing vigilance of risks to children. ***(Recommendation 8.2)***.

2.4 We saw examples of good practice in identifying victims of domestic abuse in the adult ED. This included follow up of referrals to MARAC where high risks of harm had been identified. The appointment of an independent domestic abuse adviser (IDVA) was helping to strengthen identification and support for people experiencing domestic abuse who presented in ED.

2.5 Safeguarding children practice in Rutland's MIU was weak. Consultation paperwork did not contain prompts to assist nursing staff to enquire about children's relationships or family circumstances. MIU staff reported they asked further questions if they had concerns, however, this was not evident in the case records we reviewed. Records did not reflect the voice of children including their explanation of how the injury had been caused. The full name of adults accompanying children and young people to the MIU was not routinely recorded. Records simply noted 'accompanied by mother or brother'. ***(Recommendation 5.1)***.

Case example

Z, a boy 13 years old, attended the MIU with a finger injury. He did not have a GP in Rutland, so MIU staff were unaware of his health history or any previously identified safety risks. The young person told staff he had attention deficit hyperactivity disorder (ADHD). It was recorded that he was accompanied by his older brother. The brother's name was not recorded. It was not clear from his record if the young person was seen or spoken to alone.

2.6 The quality of referrals made by Rutland's community midwives to social care was poor overall. Referrals did not contain analysis of risk and protective factors. The impact of parental needs and behaviours on the unborn or new baby was not clearly explored. Actions to protect the baby were not explicitly highlighted to aid multi-agency decision making. ***(Recommendation 8.3)***.

2.7 UHL's safeguarding leaders responded by taking immediate action to address shortfalls in the expected standards of referral practice. Community midwives were made aware of the referral processes for each of the local authorities they served. The Trust also added an additional section to its audit schedule to provide further checks of the quality of midwifery safeguarding referrals.

2.8 Priorities within UHL's improvement plan included work to strengthen its processes for making referrals to children's social care. As of 1st August 2019, the Trust's safeguarding leaders aimed to review all multi-agency safeguarding referrals to promote a consistent approach to the management of risk and help embed shared understanding of thresholds.

2.9 There are no birthing facilities in Rutland. Local women mainly choose to deliver their babies in Peterborough (North West Anglia NHS Foundation Trust) or Leicester City hospitals (UHL). UHL community midwives reported delays in being informed of the outcomes of safeguarding referrals made by the other midwifery provider. In one case reviewed, despite known historical risks to a mother's physical and mental health, their social circumstances and parental capacity; the woman delivered her baby prematurely without an agreed safeguarding plan in place. They also reported gaps in receipt of minutes and action plans from pre-discharge meetings. UHL had recognised these risks and was working with its partner midwifery provider to address them.

2.10 Midwives and health visitors had a clear pathway and effective procedures to identify and prevent harms to women and children from female genital mutilation (FGM). Health practitioners were able to access the national FGM information system and used this to review risks whenever a concern was identified. This approach supported ongoing safeguarding of girls under the age of 18 who had a family history of FGM. Enquiries were appropriately and sensitively undertaken in one case record seen.

2.11 Routine enquiries about domestic abuse were made by health visitors. LPT's safeguarding leaders ensured the 0-19 public health team was informed about the outcome of high-risk cases discussed at MARAC. Health practitioners had been trained to use the *Domestic Abuse, Stalking and Harassment and Honour based violence* (DASH) assessment tool. However, health visitors and school nurses did not routinely receive domestic abuse notifications. School nurses were dependent on being informed by schools of notifications they had received from the local police force.

2.12 Safeguarding research clearly highlights the significant and long-lasting harms exposure to domestic abuse can have on children's mental wellbeing, and on their emotional resilience and capacity to form secure attachments as they grow up. Further work was needed on a multi-agency basis to improve shared recognition of concerns and help reduce harms to children and young people associated with domestic abuse. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health team.* ***(Recommendation 2.1)***.

2.13 The health visiting service had effective procedures for managing 'no access' visits and children not brought to clinic appointments. In records reviewed, we saw missed appointments were consistently followed up and any safeguarding concerns were appropriately considered. Body maps were used effectively to identify marks on children's skin. Health visitors routinely recorded birth marks and injuries to children and explanations for the injury. This ensured effective recognition of the vulnerability of young children and denotes good progress in embedding lessons from serious case reviews.

2.14 Caseload handovers between health visitors and school nurses where there were safeguarding concerns were well managed. School nurses made effective use of chronologies to inform their review of risks and changes in children's circumstances. This in turn helped inform active caseload management to ensure priorities were met and best use was made of the local team's capacity.

2.15 School nurse referrals were of a high quality with evidence of clear recording of concerns and expected outcomes. School nurses confidently used the joint child sexual exploitation (CSE) risk assessment tool to inform their referrals to children's social care. School nurses actively followed up referrals to children's social care to check progress and next steps. In one case, where the school nurse had identified a young person was at risk of CSE, there was evidence of timely and appropriate challenge of the decision of partner agencies. This led to further investigation and support being provided for the young person. School nurses were actively engaged in CSE-related discussions and ensured young people's health needs were clearly identified and met.

2.16 The CAMHS service sought feedback from young people to help strengthen a 'young person-friendly' response to their needs. Initial contact sensitively promoted young people's engagement, with attention paid to enabling them to understand what to expect and who would be available to support them. The use of text message reminders and telephone contact helped reduce the incidence of 'was not brought to' clinic appointments. The Young Person's team reported a non-attendance rate of 4%. This denotes comparatively good performance in maintaining the engagement of young people, many of whom had been exposed to complex and traumatic early childhood experiences.

2.17 The Young Person's team generally saw children and young people looked after and those with offending behaviour within 2 weeks of referral. However, criteria for access to the Young Person's team was reported as high by LAC practitioners, with some children and young people having to wait too long before they were assessed by the specialist team. Delays continued to be seen for children waiting for neuro-development assessments. The latest data provided for Rutland (July 2019) indicated 7 children out of a waiting list of 23 had been waiting for longer than a year. This indicated some improvement on the 10 children previously waiting in March 2019 in a context of rising demand. ***(Recommendation 7.2)***.

2.18 Transition arrangements for young people who required ongoing support from adult mental health services were not consistently well-managed. In one case record seen, adult mental health practitioners were not sufficiently aware of the young person's mental health, safeguarding and care history to inform a holistic understanding of their previous adverse childhood experiences. ***(Recommendation 7.3)***.

Case example

Y is a young woman who was previously open to CAMHS. Although the initial risk assessment undertaken by CAMHS contained relevant safeguarding information concerning this young person and her baby, this was not recorded within the significant events template on the Trust's electronic case management system.

The young person did not attend the joint transfer meeting that was scheduled with CAMHS. The handover letter from CAMHS failed to include relevant information about her safeguarding history. This meant adult mental health practitioners were not fully aware of her needs and risks to her safety.

2.19 MPT's sexual health services had appropriately flagged all children in the Leicester City, Leicestershire and Rutland area who were known to be at risk of CSE. This helped ensure early recognition of their vulnerability should the young people present for help at one of the local clinics.

2.20 Screening for sexual harms and CSE risk was appropriately managed by MPT's sexual health practitioners. Safeguarding practice reflected the key domains outlined within the *'Spotting the Signs'* assessment tool. Children under 16 years of age benefited from a comprehensive risk assessment. This included appropriate coverage of wider contextual risks to children and young people.

2.21 Assessments of young people aged 16-18 years of age had a clear focus on capacity and consent. The assessment process could be further strengthened through direct use of the young person's own words to provide a dynamic picture of their experience and understanding of risks to their wellbeing and safety. ***(Recommendation 9.2)***. *This was also brought to the attention of the Director of Public Health as commissioner of the sexual health team.*

2.22 Turning Point, the adult substance misuse team, effectively identified and recorded the details of children of adults accessing its local clinics. Genograms were routinely used to identify children within households. The *'Think Family'* approach was well-embedded within operational service delivery. Practitioners were alert to wider risks including domestic abuse and poor mental health that may impact on parental capacity to nurture and protect their children.

2.23 Concerns shared by Turning Point practitioners to children's social care however were not backed up by written referrals in line with the Local Safeguarding Children Board (LSCB) guidance; although the concerns raised were clearly recorded in their case notes. Turning Point practitioners reported they did not get feedback from Rutland children's services about the outcome of safeguarding referrals ***(Recommendation 10.1)***. *This was also brought to the attention of the Director of Public Health as commissioner of the substance misuse service.*

2.24 Adult substance misuse case records provided a clear focus on the voice and experiences of children within the household. In one case record, we saw effective identification of neglect where the substance misuse practitioner had escalated her concerns about the lack of toys and food in the family home. The practitioner played an active role alongside children's social care in helping to support the delivery of the child in need plan. Partnership working between local GPs and Turning Point was also good and supported a co-ordinated approach to the care and protection of children and young people.

2.25 Adult mental health records contained limited or incomplete information about children or young people living in the household. There were gaps in recording relevant historical risks, including previous perinatal concerns. The *'Think Family'* approach was not effectively driving safeguarding practice in Rutland. Adult mental health practitioners did not adequately consider or explore risks to children or the impact of any changes in parental mental health needs on their parenting capacity and the lived experience of their children. Joint working with other teams and agencies to help secure better outcomes for children and young people was weak. Shortfalls in practice in this area were also noted in the Leicestershire CLAS review. ***(Recommendation 7.4)***.

2.26 The GP practice visited held regular family liaison meetings with a range of health practitioners. This helped ensure prompt identification and a shared understanding of risks to children to inform continuous improvement in safeguarding children practice. For example, recognition of the potential vulnerability of children educated at home is now routinely flagged on practice records.

2.27 The local GP practice was vigilant to risks to children who had not been brought to appointments. A clear protocol was in place to ensure timely follow up with families. Outstanding concerns were discussed at family liaison meetings, and as appropriate, escalation or additional help was sought.

2.28 Referrals made to children's social care by the GP practice identified risks of harm to young children. The outcomes of these referrals were clearly documented on children's records. All ED attendances were appropriately screened for safeguarding concerns to inform ongoing vigilance of risks to children.

3. Child Protection

3.1 UHL's child protection information system (CP-IS) in Leicester Royal Infirmary was fully operational. This actively supported ED and maternity staff in checking for children who were on child protection plans or looked after. It also helped ensure timely information- sharing with partner agencies about their presenting needs.

3.2 Rutland's Walk in Centre staff did not have access to CP-IS, and so were unaware if children were on statutory plans or had any previous presentations to emergency or urgent care. Arrangements for accessing children's health histories were variable. Whilst the records of Rutland GP practices who use SystmOne could be checked, there were gaps in access to local GP practices using other electronic case management systems and those located outside Rutland. Further review of these arrangements was needed to provide assurance of the effectiveness of current arrangements in identifying and protecting vulnerable children. ***(Recommendation 5.2)***.

3.3 Child protection arrangements in Rutland reflected its relatively small population size and levels of child safeguarding activity. Health practitioners made safeguarding referrals directly to Rutland's social care duty team. Health practitioners were usually involved in strategy discussions with efforts made to ensure the attendance of the practitioner who knew the child and family best. All child protection meetings reviewed in the last quarter 2018/19 included at least one representative from health.

3.4 Safeguarding records held by or available to Rutland's community midwives were fragmented. This had been raised as an area for improvement in Leicestershire's CLAS review. Whilst paper copies of referrals and child protection plans were held securely in the locality team's base, relevant additional information such as conversations with children's social care and details of referral outcomes were not able to be accessed locally given the limits of UHL's current IT system (E3). Most safeguarding records were held on a separate central database overseen by the Trust's safeguarding midwifery team. This risked building in delay whilst the community midwife sought further information to inform their ongoing monitoring of risk, including out-of-hours.

3.5 Senior leaders in UHL clearly recognised the enduring nature of these risks until its modernisation programme for maternity case recording was complete, with an expected timescale now agreed for May 2020. Practice had been recently audited and reported to the Trust safeguarding assurance committee which indicated midwives were making appropriate checks of all systems to prevent relevant information being missed. Safeguarding leaders reported they would continue to audit compliance to ensure concerns were effectively monitored and managed by midwives in the interim. This issue remained as an area for priority attention on UHL's risk register.

3.6 UHL's midwifery child protection reports were of good quality. The potential impact of safeguarding concerns on the unborn child were clearly articulated, as were the actions required to keep the baby safe. Child protection reports indicated good understanding and use of the '*Signs of Safety'* model.

3.7 Sharing of information and joint working between health visitors and community midwives generally worked well. Good practice was seen in the handover arrangements of a new baby. Follow up by the health visitor evidenced a high standard of professional curiosity about adults in the household and mother's mental health. They acted quickly to alert others to escalating risks of domestic abuse and wider harms to this vulnerable mother and her new born baby.

3.8 Flagging of the status of children on protection plans and children looked after was well-managed on the records of the 0-19 public health team. Workload management reflected priority work required to safeguard children.

3.9 The quality of child protection reports written by health visitors was variable. Reports seen did not consistently capture the voice of the child or the impact of poor parental care on children's development and wellbeing. Other reports however included valuable observations such as home conditions and the quality of parent-child interactions. The quality of reports appeared to be practitioner dependent. Local arrangements had not been assured by regular audits of practice. ***(Recommendation 7.5)***. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health team.*

3.10 School nurses were effectively engaged in all relevant *'team around the child'*, children in need and child protection meetings. This helped ensure good oversight of escalation of risks and of progress being made in improving outcomes for children. The use of the baseline health needs assessment tool provided a clear picture of children's needs and helped identify which health practitioner was best placed to support them. It provided a transparent process for identifying children and their families who required additional support and for tracking when work had been completed. Reports to child protection conferences prepared by school nurses were of a very good standard.

3.11 Joint working arrangements between Rutland's social work lead professional and LPT's specialist health practitioner for CSE were well-established. Both practitioners actively supported the development of CSE safeguarding practice with wide implementation of CSE screening tools to inform assessment and ongoing review of risks. All children at risk of CSE were seen within 24 hours of referral. This denoted a high standard of practice to promote early engagement and holistic assessment of children and young people's needs.

3.12 MPT's sexual health practitioners were not usually invited to contribute to strategy discussions or child protection meetings even in circumstances where they had made a referral escalating their concerns about risks to children. There was potential to strengthen information sharing and operational networks to further improve joint working arrangements. ***(Recommendation 9.4)***. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

3.13 The Young Person's team (CAMHS) has strengthened its focus on wider safeguarding risks that impacted on children's emotional and mental wellbeing and safety. This included making use of drugs and alcohol, CSE and neglect screening tools to inform their understanding of young people's presenting problems. Such approaches were helping to promote shared understanding of risk and joint working with other agencies. This for example included targeted work with sexual health services to enable a young person to manage their anxiety so that they could attend relevant appointments to address outstanding sexual health issues.

3.14 Risk management plans developed by Turning Point adult substance misuse practitioners included clear identification of risks to children. Turning Point practitioners routinely made home visits to adults with opiate misuse and provided locked boxes to enable them to safely store medication. Its electronic case management systems appropriately flagged such households. Safety plans were created and shared with other agencies, such as health visitors who were key partners in helping to deliver the child protection plan.

3.15 Attendance by Turning Point practitioners at child protection conferences was good. Child Protection reports prepared by adult substance misuse workers were strengths-based and had a clear focus on the needs and potential risks to children.

3.16 Risk identification and management plans in the adult mental health service did not effectively identify parenting capacity or the impact for children. Child in need and child protection plans were not clearly visible or easy to locate on LPT's adult mental health electronic case management system. We found a lack of professional curiosity to encourage vigilance and exploration of the signs of potential risks to children. The *'Think family'* approach was not fully embedded. For example, risks were not always considered and recorded in relation to the safe management of medication within the home. ***(Recommendation 7.4)***.

3.17 Joint working between child and adult mental health practitioners was limited on case records seen. The engagement of adult mental health in child protection meetings and joint working with other local teams and partner agencies was weak. This was an area highlighted for improvement in Rutland's annual children protection report (2017-18). The impact of their absence was clearly evidenced in one case record where despite this being flagged as critical to the development of the child protection plan, the contribution of adult mental health practitioners was lacking. This significantly hindered other partners having a clear understanding of risks including the impact of the parent's long term and deteriorating mental health on the children. ***(Recommendation 7.6)***.

3.18 Children in need and those on child protection plans were clearly flagged on GP records. Relevant protection plans were attached to the child's record. Contact details of children registered at the practice were linked to their family members to enable ease of tracking of the impact of changes in parental wellbeing or capacity on the safety and welfare of children. Systems worked well in responding to requests for GP's to attend case conferences or provide reports for child protection meetings.

4. Children Looked After

4.1 The Looked After Children's health team was not always informed in a timely manner of children being taken into care by Rutland County Council. This in turn impacted on the capacity of the health provider to offer clinic appointments that complied with activity timescales outlined in *'Promoting the health and wellbeing of looked after children'*- the statutory guidance on the planning, commissioning and delivery of health services for looked-after children (2015).

4.2 Social workers were expected to attend all initial health assessments (IHAs) to support information sharing between agencies about what was known about the child's history. We reviewed one IHA where the social worker had not been present or shared essential information with health partners about the vulnerability of a young person. This meant key information needed to help the young person understand and feel safe whilst they were being medically examined was not available to effectively plan for and manage their anxieties. This resulted in the initial health assessment having to be suspended and re-scheduled.

4.3 Although there were regular meetings between health and care professionals and close relationships established with respective administration teams, the quality of practice was not yet effectively secured by an integrated approach to meeting the health needs and improving outcomes for children looked after. ***(Recommendation 3.1)***.

4.4 The quality of assessment and coverage of concerns about children's health and wellbeing in 2 IHAs and care plans reviewed did not support age or clinically appropriate practice. These records did not reflect the voice of the child. There were gaps in consideration of children's emotional and mental health needs and of parental health histories. In one case, whilst a care navigator had been tasked to provide parental health histories, this was not used to inform the child's health record or vigilance to future risks. Although IHAs were quality assured by the named doctor for looked after children; the quality of practice was adversely affected by the knowledge, experience and turnover of medical staff undertaking this work. ***(Recommendation 3.2)***.

4.5 Some health care plans did not clearly record relevant actions to address the range of risks identified. Action plans had loose timeframes such as *'needs to attend the dentist annually'*, but this was not informed by their previous attendance. In another health care plan, the additional help a child with learning difficulties needed was not included, although the assessment noted the child was experiencing memory problems. Lack of clarity in turn impacted on the effectiveness of local arrangements for assessing the impact of and outcomes of key actions. ***(Recommendation 3.2)***.

4.6 The timeliness and quality of review health assessments and care planning for children placed out of area was variable. LPT was working to address this through the appointment of care navigators to improve scrutiny of their needs. Despite this development and the use of a '*Payment by Results'* audit completed by the designated CLA nurse; challenges remained in effectively influencing the quality of assessments and care plans undertaken by other agencies. This was a significant risk given most of Rutland's looked after children were placed outside the area. ***(Recommendation 3.3)***.

4.7 Children and young people under 16 years of age were not routinely offered a choice of time and place for their review health assessment (RHA). If a young person failed to attend their health appointment, they were then offered a visit at school or in their care placement. Young people over the age of 16 years were however routinely offered a choice of time and location. In these cases, young people's preferences were clearly recorded on their care records. ***(Recommendation 7.7)***.

4.8 All emergency and urgent care attendances were clearly logged on children's records by the CLA nursing team and used to update children's health assessments and ongoing monitoring of risk. Health practitioners recognised their corporate parenting responsibilities and ensured ongoing risks to children's health or development were appropriately identified and addressed.

4.9 The emotional health and wellbeing of children looked after in Rutland was not consistently assessed and used to inform the child's RHA. Best use was not being made of the Strengths and Difficulties Questionnaires (SDQs) and other relevant mental health tools to inform a shared understanding of risk, use of scoring systems or early identification of additional help and support they may need. In other case records seen, whilst details were provided about children's emotional and mental health needs, the use of terminology was not always appropriate or risks effectively evidenced and recorded. CLA nurses reported they would welcome additional development and supervision of their work in this area. ***(Recommendation 7.8)***.

4.10 The local area had a 'fast track' care pathway to help promote a timely response to referrals made to the Young Person's Team (CAMHS). The team offered a consultation clinic in Rutland once a month. This helped identify children and young people who would benefit from direct work. Sometimes however, the waiting time for access for care and treatment was slow. LAC practitioners expressed ongoing concerns about delays in access for some children and young people who were looked after. Children were waiting twelve and eighteen weeks respectively to be seen on case records sampled. ***(Recommendation 3.4)***.

4.11 We saw good practice in the work undertaken by the Young Person's team with children looked after.

Case Example

Z is an adolescent living in foster care. She had a traumatic early childhood including exposure to domestic abuse, neglect and intra-familial sexual abuse. She was being supported by the Young Person's Team (CAMHS).

Recording of direct work by the Young Person's Team demonstrated sensitive engagement and use of assessment tools to help her safely reflect on her childhood experiences and the impact this was having on her emotional and mental health. From her initial response *'I do not want to be here';* a trusting relationship had developed with her therapist. This was enabling her to be more aware of and build personal strategies for managing episodes of poor mental health.

Her foster carer was also actively involved in helping to build a comprehensive picture of the young person's lived experience and risks. They contributed to the development of her safety plan, including identifying contingencies for responding to escalating risk. The foster parent had previously attended a trauma and abuse parenting group delivered by CAMHS. This helped build their awareness and confidence in understanding and sensitively meeting her needs.

4.12 Care navigators provided additional support and tracking of actions required to meet the complex health needs of children looked after. Further work was needed to co-ordinate the work of wider practitioners involved in supporting children and young people with special educational needs and disabilities. Education, health and care plans, youth justice assessments and CLA health assessments were not aligned to support a holistic picture of the diversity and complexity of children's needs and circumstances. This meant the young person was at risk of experiencing a disjointed approach to having their individual needs assessed and met. No single health practitioner held a comprehensive picture of the young person's needs or their desired outcomes. ***(Recommendation 3.5)***.

4.13 Information sharing and joint working between the CLA health team, GPs and CAMHS was not embedded to support enhanced identification and monitoring of risks children may be exposed to. GPs and CAMHS practitioners were not routinely asked to contribute to health assessments and plans. Whilst SystmOne enabled easy access to a range of assessments and plans, practitioners focused largely on their own specific area of practice. This did not make best use of all available information to promote joint approaches to the delivery of care. The CLA nursing team did not have an agreed standard operating procedure to support its work in this area. ***(Recommendation 4.1)***.

4.14 The GP practice we visited had recently completed the CCG safeguarding assurance toolkit. The lead GP reported it had helped to improve their recognition of what was working well and of areas for improvement. This included actions to ensure children looked after were registered as permanent patients. The GP practice now received relevant information about the child's previous medical history and so felt better prepared in understanding their needs and personal circumstances.

4.15 Following the Leicestershire CLAS review, LPT had strengthened the capacity of its CLA nursing team responsible for meeting the health needs of all children looked after over the age of 5 years. Additional capacity has enabled a strong health promotion element to be embedded within assessments and health care plans. For example, sexual health and relationships advice and smoking cessation was routinely offered within RHA's.

4.16 Other areas that demonstrated improvements in practice included capturing the experience of children on i-pads following RHA's. The processes for handling blood- borne virus screening between community and hospital-based clinicians had been aligned to help reduce the appointment burden on children and carers. The local area had also implemented a 'decliner' pathway to include the offer of follow up support by a care navigator for children and young people who missed clinic appointments.

4.17 Case records of Rutland's young people seeking asylum displayed sensitive exploration of young people's history, health needs and the impact of their journey and experiences prior to arriving in Rutland. This recognised the significant trauma young people may have been exposed to from gangs, trafficking and sexual assaults. Assessment and care planning thoughtfully considered risks to their future mental health. Records included details of relevant evidence-based therapies the young person may wish to consider at the point they felt ready to ask for additional help.

4.18 Health practitioners provided consultation, support and training to foster, adoptive and residential care staff on request. A recent training day for foster carers co-delivered by the CLA nursing team, speech therapists and CAMHS however had poor attendance. The reasons for this were being explored with children's social care. This remained an important area of activity given the need to ensure frontline carers remain confident and suitably skilled to effectively meet individual needs and safety concerns for the children they are caring for.

4.19 The quality and person-centredness of information included in the care leavers documentation was limited. The process was not young person-centred or effective in enabling them to understand their health histories and manage areas of ongoing vulnerability. One record seen largely contained public information on how to access health services; but did not provide relevant personal information about their own or family's health history. Consultation with the Children in Care Council about the use of health summaries for care leavers had started but was still at an early stage in influencing changes to practice. ***(Recommendation 7.9)***.

5. Management

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

5.1 Leadership and Management

5.1.1 Designated professionals and senior leaders in Leicester, Leicestershire and Rutland (LLR) CCGs demonstrated a clear vision, commitment and drive in working with a broad range of partner agencies to support continuous improvement in safeguarding children practice. '*Signs of Safety'*, CSE identification and neglect tools were strongly promoted by senior leaders to help build a shared culture and recognition of risk. The identification of children exposed to radicalisation was growing (the PREVENT agenda). This included examples of good joint working between health leaders, Rutland County Council and schools in the management of risk.

5.1.2 As highlighted in the earlier sections of this report, we found good and growing confidence in the use of the *'Signs of Safety'* tool by frontline health practitioners to inform their safeguarding children practice. This helped ensure clear expectations and support for their work with children and families. Practitioners' understanding of sexual grooming and exploitation of children was being continuously strengthened, with appropriate use of the *'Spotting the Signs'* tool to promote greater levels of vigilance and timely escalation of concerns. Child health practitioners' use of neglect tools was inconsistent however, and research by the LSCB indicated variability in confidence and use by practitioners. There was potential for further review of the use and application of the neglect tool in Rutland's context.

5.1.3 Whilst Turning Point had a strong focus in its operational management and safeguarding leadership in relation to *'Think Family',* the approach in adult mental health services remained under-developed. The reasons for this need to be clearly understood to promote a consistently strong safeguarding culture and good joined up working with children's health and social care practitioners. ***(Recommendation 7.4)***.

5.1.4 Designated safeguarding and quality leads in the CCGs had a well-developed understanding of local safeguarding children priorities that clearly reflected the new safeguarding reforms and local programmes of work. Action plans effectively mapped out the local area's improvement trajectory, with strengthening of contract monitoring processes to support a high standard of service delivery. The local area's CCGs together with NHS England had developed a shared procurement template to help drive improved standards of practice in how health services were commissioned. This was helping to promote greater efficiencies in joint working and oversight of compliance.

5.1.5 The LLR-wide *'Safeguarding Effectiveness Group'* chaired by the designated nurse for safeguarding ensured a strong, shared and co-ordinated approach between local health providers in implementing improved standards of practice and outcomes for children. The LLR-wide monthly multi-agency performance management meetings also helped strengthen oversight of operational delivery and promoted shared problem-solving and the development of joint plans.

5.1.6 Since January 2019, all high-risk domestic abuse case discussed at MARAC have been routinely shared with GPs. GPs received additional training to enable them to understand their professional accountabilities enabling increased recognition and reporting of concerns. Local leaders acknowledged further work was needed on a multi-agency basis to ensure frontline health practitioners were also informed about medium and low risk notifications to help strengthen early help and prevention. ***(Recommendation 2.1)***.

5.1.7 Midlands Partnership NHS Foundation Trust (MPT) however was not involved in any joint working CSE or 'Missing Children' groups with partner agencies. Partnership working required further development to promote their visibility and enable mutual sharing of intelligence and expertise within wider multi-agency service development and risk management activity. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.* ***(Recommendation 9.4)***.

5.1.8 Commissioners and providers of services demonstrated a good and growing focus on listening to and responding to the views and experiences of children. and young people. Young people from Rutland alongside others from Leicester City and Leicestershire were actively contributing to the LSCB's priority workstream to help embed the 'voice of the child' in all its work. Work in progress at the time of this review included the production of a short film to promote the spirit and standards of practice set out in the United Nations Convention of the Rights of the Child. The children's strong message to health and social care professionals was '*no decision about me, without me'.*

5.1.9 Local health and social care leaders had a clear focus on actions needed to improve access timescales, alignment and integration of 'step-up' and 'step-down' responses and enhance the experiences and outcomes for children and young people using CAMHS specialist services. Rutland children had to travel to CAMHS clinic appointments in Leicester City some distance away, with limited local service availability. Progress in securing the delivery of local transformation plans was impacted by the recent delay in being able to procure a provider to manage the new triage and navigation system. Designing and delivering continuous improvement in approaches to meeting local need remained a high priority for local partners.

5.1.10 LPT's leaders had responded in an open and inclusive manner to areas for improvement for specialist CAMHS services identified in previous inspections. The Trust had comprehensively reviewed its capacity and performance. Timeliness performance was improving and tightly monitored, whilst demand remained high. Safeguarding practice improvements seen in the quality of direct work by the Young Person's team are referred to in earlier sections of this report.

5.1.11 Local NHS safeguarding leadership capacity however does not meet the requirements set out in intercollegiate guidance '*Safeguarding Children and Young People: Roles and Competencies for health care staff*' (2019). Capacity challenges were included on the CCG's risk register. This was also identified as an area to strengthen in the Leicestershire CLAS review. The CCGs recently added a new safeguarding post to help strengthen its development and assurance capabilities. However, safeguarding leadership and development capacity remains challenging given the geographic size and coverage with the designated safeguarding team serving three distinct localities, at a time of significant change and need for continuous improvement in safeguarding children's practice. ***(Recommendation 1.1)***.

5.1.12 The capacity of the named and designated doctor for looked after children remained a risk. The Leicestershire CLAS review previously identified the need for separation of the designated and named doctor roles to help avoid potential conflicts of interest. This had not yet been actioned at the time of the Rutland review. Further review of the workload and capacity to address development priorities was needed. The capacity deployed to both roles- an allocation of 1.5 days per week for the whole of the Leicester City, Leicestershire and Rutland localities was comparatively limited. ***(Recommendation 1.2)***.

5.1.13 Since the Leicestershire CLAS review the roles of designated and named nurse for children looked after had been separated. The capacity of the specialist CLA nursing team had also been strengthened, and all vacant posts were appointed to. The team offered a new case holder model of care delivery which had helped to strengthen follow up of children's needs and support for carers. Checks were undertaken 4-6 weeks following the IHA to monitor progress in meeting the child's immediate health needs and risks. This approach was helping to strengthen recognition of health inequalities and any delays or barriers to accessing specialist intervention.

5.1.14 The capacity of UHL's named midwife was very stretched; given the large geographical area covered, with over 10,000 births each year. As seen in the early sections of this report, there were additional operational challenges for Rutland's community midwives in ensuring effective contact and joint working with other maternity providers. The named midwife was also responsible for antenatal services, foetal medicine and screening; and fulfilled the role of lead midwife for UHL. Following this review, senior leaders in UHL planned to review their job plan and safeguarding capacity. ***(Recommendation 8.4)***.

5.1.15 The school nursing team had a robust operational delivery model that included a clear contingency plan for managing risk if the capacity of the team was reduced. This made best use of information and communication technology systems to promote a strong local presence and attention to priority work.

5.1.16 Some ongoing workforce capacity challenges were evident in the health visitor workforce covering Rutland and Melton. Health visitors had comparatively high caseload numbers, significantly above recommended levels. The service offer had been adapted to workforce availability; with extended timescales for mandatory visits or targeted interventions rather than the full '*Healthy Child Programme'* offer. *This was also brought to the attention of the Director of Public Health as commissioner of the health visiting service.* ***(Recommendation 7.10)***.

5.2 Governance

5.2.1 Governance and oversight of safeguarding children activity by NHS Leicester, Leicestershire and Rutland CCG's was strong. The CCGs Safeguarding Assurance Tool set clear expectations of quality standards and outcomes for children and adults at risk of abuse and neglect, including children looked after. Safeguarding assurance tools were increasingly effectively used by NHS providers to report on their performance in safeguarding children and adults at risk of harm.

5.2.2 Designated and named safeguarding professionals together with senior leaders provided appropriate challenge, support and review in assessing progress in implementing learning from serious case reviews, domestic homicides and previous inspection reports. This helped ensure a strong shared focus on individual and joint accountabilities, and of the effectiveness of improvement actions taken. Rutland's health practitioners had strengthened practice in identifying bruising in pre-mobile babies. A baseline audit of practice had been repeated during 2018-19 and the report was in the final stages of completion. The was an agreed system for addressing the communication needs of families whose first language was not English.

5.2.3 Oversight of the quality of safeguarding practice in primary care had been significantly strengthened through the introduction of the 'Quality Markers' self-assessment process. We saw it had been used well by the Rutland GP practice we visited, where it had encouraged open reflection and analysis of strengths and gaps in safeguarding practice. Although completion was voluntary; it was helping to drive a clear, targeted development agenda to support stronger single and joint agency working together arrangements. In addition, the surveys developed by the named GPs provided regular checks of GP confidence, knowledge and expertise in safeguarding children work. These approaches demonstrated improved accountabilities and a maturing governance structure.

5.2.4 Coaching arrangements and quality assurance of IHA's by the Designated Doctor for children looked after were well-established. However, changes in the trainee medical staff undertaking IHA's on a rotational basis, meant there was an ongoing risk of continued variability in the quality of practice and recognition of the diverse and often complex health and development needs of children who are looked after. ***(Recommendation 3.2)***.

5.2.5 Governance of safeguarding activity within UHL had been strengthened since the Leicestershire CLAS review, with evidence of good senior management scrutiny and learning from safeguarding incidents. Improvements in practice were clearly scoped and secured by a 'master action plan' with strong promotion of mandatory training. The recent appointment of a new named doctor for safeguarding children was helping to build recognition and expertise of medical staff in safeguarding children.

5.2.6 UHL's safeguarding leaders recognised the need to have greater assurance of the quality of safeguarding practice within ED. The Trust's safeguarding team intended to review all multi-agency referrals to children's social care to assess their quality and practitioners' understanding of significant harm thresholds. As seen in the earlier sections of this report, further assurance was needed of adult ED practitioners' recognition of the vulnerability and status of young people aged 16 and 17 years and of the parental and caring responsibilities of adults.

5.2.7 UHL was working to address gaps in its information and communications technology systems to provide more efficient and safe methods for information-sharing within the Trust and between partner agencies. The Trust's risk register and action plans reflected the work required to modernise and streamline its case recording systems, including improvements in support for its community midwives.

5.2.8 LPT ensured all multi-agency referrals to children's social care were clearly flagged and shared with service leads. This helped ensure good management oversight of levels of safeguarding activity and operational demands. However, practitioners in LPT could not easily find key third-party child safeguarding information placed on SystmOne. Such information had been scanned and placed in folders that were not clearly identifiable in relation to specific meetings, reports and plans. This led to delays and risked key documentation being missed by busy practitioners carrying out their daily work. ***(Recommendation 7.11)***.

5.2.9 LPT's leaders had actively promoted practice improvements to strengthen the quality of its CAMHS risk assessment and safety planning processes. Each CAMHS team had a designated safeguarding lead who participated in wider Trust network meetings and ensured regular sharing and feedback on practice. The young person's CAMHS team held monthly peer case audits of its record keeping practice. This was helping to drive shared recognition of the required standards of assessments, care and safety plans. Monthly *'Are We Safe'* team meetings led by the team manager enabled wider discussion about children with current or emerging safeguarding concerns. These examples denote strong ownership and support by frontline practitioners in working together to keep children and young people safe.

5.2.10 Scrutiny and assurance of the quality and impact of '*Think Family'* safeguarding work in LPT's adult mental health services in Rutland however, was relatively weak. We found limited evidence of its effectiveness in supporting wider safeguarding children work. ***(Recommendation 7.6)***.

5.2.11 Quality assurance of safeguarding practice was well managed by Turning Point. Effective quality assurance processes, including use of case audits, supported vigilance of the standards of frontline practice and helped to embed organisational learning.

5.2.12 MPT did not have a programme of audit for monitoring the quality of safeguarding children practice undertaken by its sexual health practitioners. This was an essential gap in the Trust being able to provide assurance that the required standards of safeguarding children practice, including for children at risk of CSE or child sexual abuse were being delivered. Given the level of risks and complexity of some young people's needs and circumstances, and the need to embed learning from local safeguarding reviews; further assurance was needed of the knowledge and competencies of front-line staff. *We brought this to the attention of the Director of Public Health as commissioner of sexual health services.* ***(Recommendation 9.5)***.

5.3 Training and supervision

5.3.1 Training for GPs included a strong focus on their accountabilities for domestic abuse. The provision of level 3 safeguarding children training for primary care within the East Leicestershire and Rutland CCG locality was good, with a 97% reported coverage rate.

5.3.2 Safeguarding children training for the Walk in Centre nursing and receptionist staff was not compliant with intercollegiate guidance '*Safeguarding Children and Young People: Roles and Competencies for health care staff*' (2019). Nursing staff completed on-line training only. They had not received training in all relevant areas of practice, including awareness of the needs of children at risk of CSE. Nursing staff were not clear about local authority thresholds for significant harm, which may lead to their not making appropriate referrals to other agencies. These matters need to be urgently addressed to provide assurance its workforce has the confidence, knowledge and skills they need to keep children and young people safe. ***(Recommendation 5.3)***.

5.3.3 UHL had set an ambitious target of 95% for safeguarding children coverage. At the time of this visit, training attendance by the Women and Children's directorate was reported at 93% coverage. This denotes a significant improvement since the Leicestershire CLAS review.

5.3.4 Although UHL had a clear safeguarding supervision policy and all supervisors had received appropriate training; implementation was not effectively embedded in the work of frontline teams, and uptake remained poor. Safeguarding supervision arrangements in midwifery were evolving, but the offer was still relatively limited. UHL needed to progress full implementation of its plans to introduce its new supervision model. This would assist in strengthening workforce capabilities and enable proactive tracking of continuous improvements made in safeguarding children practice. ***(Recommendation 8.5)***.

5.3.5 LPT's leaders reported growing risks to the delivery of its safeguarding training to meet the requirements set out in intercollegiate guidance. It identified a lack of capacity within its safeguarding team to design and deliver the range of learning activity needed to sustain and continuously improve its performance. This was flagged as a risk on the Trust's risk register. ***(Recommendation 7.12)***.

5.3.6 Good practice was seen in the Young Person's CAMHS team where the designated safeguarding lead accessed the full 5 day *'Signs of Safety'* training. The impact of this was clearly seen in supporting wider team safeguarding children development work.

5.3.7 Access to safeguarding children supervision was not consistently delivered within LPT. Whilst school nurses had good access to scheduled and 'ad hoc' supervision; with attendance clearly recorded and monitored; health visitors did not receive regular one to one safeguarding supervision. Supervision for CLA nurses was also primarily 'ad hoc'. Given the nature and complexity of the needs of some children looked after, a more structured and developmental approach was required. The offer of safeguarding children supervision to adult mental health practitioners was limited. Quarterly action learning sets were the main vehicle used by LPT for offering support and reflection on practice. Such arrangements did not provide the levels of case oversight and assurance of the performance of individual practitioners ***(Recommendation 7.13)***.

5.3.8 Turning Point's workforce accessed level 2 safeguarding training. Practitioners working with children and families are likely to require a higher level of knowledge and competences. Level of expertise had not been mapped against intercollegiate level 3 guidance to provide assurance that practitioners had the required level of knowledge and skill in safeguarding children. *We also brought this to the attention of the Director of Public Health as commissioner of substance misuse services.* ***(Recommendation 10.2)***.

5.3.9 MPT's sexual health teams had access to a lead nurse for safeguarding who was reported to be familiar with the specific local area children protection policies and procedures. The training delivered was reported to be in line with intercollegiate level 3 requirements. However, the local team had not yet had any County Lines/criminal exploitation training and would welcome this. *We also brought this to the attention of the Director of Public Health as commissioner of sexual health services.* ***(Recommendation 9.3)***.

Recommendations

1. NHS England together with Leicester City, Leicestershire and Rutland CCGs and Leicestershire Partnership Trust should:

1.1 Ensure leadership capacity and oversight of clinical practice by designated safeguarding professionals complies with intercollegiate guidance and effectively addresses local need and continuous improvement priorities.

1.2 Ensure designated and named doctor capacity for children looked after complies with intercollegiate guidance and consistently delivers the required standards of clinical practice and improved health outcomes for children looked after.

2. NHS Leicester, Leicestershire and Rutland Clinical Commissioning Groups together with wider safeguarding partners and Leicestershire Partnership Trust should:

2.1 Ensure all relevant health practitioners are routinely informed about children at risk of domestic abuse.

3. NHS Leicester, Leicestershire and Rutland Clinical Commissioning Groups together with Leicestershire Partnership Trust and Rutland County Council should:

3.1 Ensure effective joint arrangements for improving health outcomes for children looked after.

3.2 Ensure initial health assessments and care planning for children consistently meets standards outlined in health regulations and clinical guidance.

3.3 Ensure children placed out of area benefit from a consistently high standard of health assessments and care planning.

3.4 Ensure all children looked after benefit from timely access to support in meeting their mental health needs.

3.5 Develop an integrated approach to meeting the diverse needs of children looked after.

4. NHS Leicester, Leicestershire and Rutland Clinical Commissioning Groups together with Leicestershire Partnership Trust should:

4.1 Ensure children's health assessments are actively informed by the activity and the expertise of primary care and specialist mental health practitioners.

5. NHS East Leicestershire and Rutland CCG together with Oakham Medical Practice should:

5.1 Ensure MIU staff actively promote and record the voice of children and of their relationships and family circumstances.

5.2 Ensure MIU systems for identifying risk and protecting vulnerable children are effective.

5.3 Ensure Walk in Centre staff receive the required levels of safeguarding training in line with intercollegiate guidance.

6. University Hospitals of Leicester together with Leicestershire Partnership Trust should:

6.1 Review the impact of the enhanced notification system in helping to strengthen joint safeguarding practice and outcomes for children.

7 Leicestershire Partnership Trust should:

7.1 Ensure good information-sharing and communication with all emergency departments in neighbouring councils to ensure risks to children's safety are promptly identified and followed up.

7.2 Ensure children, young people and their families have timely access to neuro-development assessments and post-diagnosis support.

7.3 Ensure young people's adverse childhood experiences and their safeguarding history actively informs transition planning to adult mental health services.

7.4 Ensure adult mental health practitioners fully recognise parental responsibilities and risks to children and embed the *'Think Family'* approach in their practice.

7.5 Ensure child protection reports prepared by health visitors provide a consistently high standard of analysis of safety and protective factors, and reflect the lived experience and voice of the child.

7.6 Ensure adult mental health practitioners are actively engaged in and supportive of multi-agency child protection and safety planning arrangements.

7.7 Ensure all children and young people are able to be seen for their review health assessments in the place they choose where they feel safe and comfortable.

7.8 Ensure children looked after nurses are confident and appropriately skilled in assessing risks to children's emotional and mental wellbeing as they move through care and the phases of childhood.

7.9 Ensure care leavers are effectively informed about their personal health histories and enabled to manage their future health needs.

7.10 Ensure the health visiting workforce has sufficient capacity to deliver the full Healthy Child Programme.

7.11 Ensure effective management of third-party safeguarding information to enable ease of identification of safeguarding documentation.

7.12 Ensure appropriate levels and coverage of safeguarding children training for frontline practitioners and managers.

7.13 Ensure all its frontline practitioners have good and regular access to safeguarding children supervision to support their continuous professional development.

8 University Hospitals of Leicester should:

8.1 Ensure adult ED practitioners effectively screen for and act on concerns about safeguarding risks to young people aged 16-17 years old.

8.2 Ensure adult ED practitioners have the tools and support they need to routinely enquire about parental or caring responsibilities for children.

8.3 Ensure safeguarding referrals made by community midwives provide clear and effective analysis of risks and of actions required to keep babies safe.

8.4 Ensure the balance of roles and capacity of the named midwife enables the effective delivery of lead accountabilities for safeguarding.

8.5 Ensure midwifery supervision is well-embedded across the organisation and helps drive up the standards of its safeguarding children practice.

9 Midlands Partnership NHS Foundation Trust should:

9.1 Actively promote *'You're Welcome'* quality standards in the delivery of young people's sexual health services.

9.2 Ensure the voice of young people is clearly recorded within sexual health assessments to provide a comprehensive picture of their experience, wellbeing and safety.

9.3 Ensure sexual health practitioners have a good understanding of and can effectively identify the signs of wider exploitation of children and young people.

9.4 Ensure sexual health services are involved in and contribute to joint safeguarding children activity.

9.5 Ensure appropriate governance arrangements are in place for identifying and managing risk to young people accessing sexual health services.

10 Turning Point should:

10.1 Ensure referrals to children's social care are in line with local guidance.

10.2 Ensure its workforce is appropriately equipped with the levels of knowledge and expertise they need to safeguard children in line with intercollegiate guidance

Next steps

An action plan addressing the recommendations above is required from NHS Leicester, Leicestershire and Rutland CCG within **20 working days** of receipt of this report.

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