Review of health services for Children Looked-after and Safeguarding in Slough

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

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Provider services included:	• Frimley Health NHS Foundation Trust (FHFT) • Berkshire Healthcare NHS Foundation Trust (BHFT) • Solutions for Health Limited (S4H) • Turning Point
CCGs included:	• NHS East Berkshire CCG
NHS England area:	NHS England South East Region
CQC region:	South East
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Contents

Summary of the review

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

Where the findings relate to children and families in local authority areas other than Slough, 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 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 children's cases where there had been safeguarding concerns. This included some cases where children were referred to social care. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number of other such children's 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 **73** children and young people.

Context of the review

The latest published information from the Child and Maternal Health Observatory are those from March 2019. These figures are published by Public Health England at the time of writing this report and so they are used to set the context for the area.

The data shows that children and young people under the age of 20 years made up 30.5% of the population of Slough with 84.7% of school age children being from a minority ethnic group.

The proportion of children under 16 living in low income families was 15.1%, lower than the national average of 17%. Family homelessness was worse, however, at 4.1 for every 1,000 against 1.7 for England. The number of children in care was fewer with 49 as opposed to 64 per 10,000 for England.

The infant (aged 0 to 1 year) mortality rate was similar to the rest of England with 5.3 for every 1,000 live births. The child (aged 1 to 17 years) mortality rate was also similar to the rest of England 13.4 for every 100,000.

Generally, data shows that the health of children in Slough was mixed compared with England averages for a range of attributes measured. For example, immunisation rates for MMR were lower than the national average at 87.1% whereas rates for other vaccinations at the same age were better at 95.1%. Immunisation rates for children in care was much worse at 39% compared with 85.3% for the rest of England (but see below in 'looked after children' section).

Babies and children generally had healthy weights although the proportion of primary school children who were obese was slightly greater than the England average.

Whilst there were more children with missing, decayed or filled teeth than the England average, there were fewer pre-school children admitted to hospital for dental caries.

Under 18 conceptions were fewer than other parts of England with 12.2 compared to 18.8 for every 1,000. The number of teenaged mothers was also fewer than England at around 0.3% as opposed to 0.7%.

Hospital admissions for young people with mental health conditions (111.4 per 100,000) were similar to England as a whole. This was also the case for admissions of young people over 10 years of age through self-harm (433.5) and the admissions of young people aged 15 and over through alcohol or substance misuse (102.7). Admissions of young people aged under 19 through asthma were almost twice as much as the England average.

The number of children killed or seriously injured on roads was similar to the rest of England as was the number of children aged 0-14 admitted to hospital with injuries. The number of young people aged 15-24 admitted to hospital with injuries was slightly greater than the England average whereas the number of children aged 0-4 aged 0-4 attending the emergency department was slightly fewer.

The Department for Education (DfE) provide annual statistics about children who are looked-after and statistics about children who are in need or the subject of child protection plans. The most recent statistics available at the time of the inspection were those for the year ending 31 March 2018.

The number of children looked after by Slough between 2014 and 2018 has fluctuated but has remained close to the average of 305. The number of children who had experienced some time in care during the 2017-2018 year had slightly increased from the previous year from 295 to 313. 125 children were new to care whereas 112 had ceased to be looked after. Fewer unaccompanied asylum-seeking children (8) were looked after by the Slough local authority than in previous years.

There were 161 children in Slough who were the subject of a child protection plan as at the end March 2018. There were also 1,223 episodes of children in need in Slough during the year April 2018 to March 2018.

Commissioning and planning of most health services for children, including children's mental health services and specialist services for looked after children, were carried out by NHS East Berkshire CCG and Slough Public Health, Slough Borough Council.

The looked-after children's health service was provided by Berkshire Healthcare NHS Foundation Trust (BHFT) with initial health assessments carried out by community paediatricians and review health assessments for children aged 16 and 17 and care leavers carried out by specialist nurses for looked after children. Review health assessments for children under five and children of school age who attended a Slough school were carried out by health visitors and school nurses respectively from Solutions 4 Health. Review health assessments for looked after children who attended a school outside Slough were carried out by school nurses from the relevant providers operating in the area where the child attended school (see paragraph 4.1 below).

Acute health services, including emergency care and maternity were commissioned by the CCG and provided by Frimley Health NHS Foundation Trust (FHFT), primarily from Wexham Park Hospital (WPH).

The integrated 0-19 public health services, including health visiting and school nursing were commissioned by Slough Public Health and provided by Solutions 4 Health Limited.

Child and Adolescent Mental Health Services (CAMHS) were commissioned by the CCG and provided by BHFT as were mental health services for adults.

Contraception and sexual health services (CASH) were commissioned by Slough Public Health as part of the Berkshire Public Health shared team and provided by BHFT. GPs in Slough and community pharmacies were also commissioned by public health to provide contraception (emergency contraception only in the case of pharmacies).

Both children's and adults' substance misuse services were commissioned by Slough Public Health and provided by Turning Point.

The last inspection of safeguarding and looked-after children's services for Slough that involved health services took place in June 2011. This was a joint CQC and Ofsted inspection. Then, the effectiveness of arrangements for safeguarding children were judged as 'inadequate' although the contribution of health services to keeping children safe was rated as 'good'. The overall effectiveness of services for looked after children and young people were rated as 'adequate' with a rating of 'good' for looked after children being healthy.

Ofsted carried out a single agency inspection of Slough council and safeguarding children board (SSCB) in January 2019 and judged that the area 'required improvement'. We have taken into consideration the findings during this review.

Both Berkshire Healthcare NHS Foundation Trust (published October 2018) and Frimley Health NHS Foundation Trust (published March 2019), including Wexham Park Hospital, have been recently inspected by CQC and rated as 'good'.

Health services in Slough followed the SSCB procedures, derived from the online resources used across neighbouring areas under the Pan Berkshire Safeguarding Children Procedures. At the time of our review, professionals working with children in Slough used the Slough thresholds guidance. The guidance describes levels of intervention closely associated with those described in Working Together to Safeguard Children (2018); broadly, support through universal services, early help, children requiring specialist support and children in acute or urgent need.

During our review we looked at the effectiveness of health practitioners' engagement with the process and the Slough Children's Services Trust (children's social care) and our findings are outlined in this report.

The report

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

What people told us

All of the views expressed here are from the young people of the REACH group, Slough's children in care council, and related to their experience of their annual looked after children's health assessment carried out by the providers described in the section above.

Young people reported they have yearly appointments with the looked after children nurse. One young person said:

"I have my height and weight checked and get asked a lot of questions".

Another young person told us:

"It's a waste of time as it's the same things every year".

One young person told us:

"Young people have their health assessments mainly at school, which can be embarrassing when I am taken out of class and my friends ask my questions."

Another young person had their assessment at home when other people were in the house. They said

"It was embarrassing; not very private."

One young person said:

"I see my school nurse every year, she really understands and listens to my views".

Another young person told us:

"My GP is really good and knows my family but it can be difficult to get an appointment".

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 Health services in Slough generally had effective approaches to identifying children and families with additional needs and in providing appropriate support to those families. Some areas demonstrated good practice whereas some areas were less effective due to variable practice or limited use of tools as are set out below.

1.2 Most women accessed midwifery services having first seen their GP. Community midwives held antenatal clinics in GP surgeries and midwives reportedly attended GP vulnerable families meetings when invited, alongside colleagues from the 0-19 health visiting service. This strengthened information sharing between the midwives, the 0-19 service and GPs and enhanced opportunities to plan care more effectively for those families.

1.3 We did not see sufficient evidence of a 'Think Family' approach in maternity records at Wexham Park Hospital (WPH). This indicated that pregnant women booking their care were not always comprehensively assessed. The booking templates did not support staff to fully explore social history, family composition or adverse childhood experiences. The forms did not prompt midwives to document full details of partners or fathers and the details of any other children. There was an overreliance on professional curiosity by the midwife, or a disclosure from the woman herself about areas of vulnerability, and this means that additional needs or risks might not be well identified. ***Recommendation 1.1***.

1.4 In those instances when safeguarding concerns were identified in maternity, or where pregnant women had particular vulnerabilities, midwives used a targeted ante-natal form to share information with health visitors. However, of the referrals we reviewed, not all were fully completed and there was limited analysis of risk or impact of parental circumstances on the unborn child. ***Recommendation 1.2***.

1.5 When identified, the most vulnerable pregnant women received ante-natal home visits from specialist safeguarding midwives in the 'Crystal' team. Midwives offered all antenatal care at home, and this improved engagement with the service. In addition, health visitors offered ante-natal home visits to vulnerable women. Both initiatives provided the opportunity for assessing risks in relation to home circumstances when there were identified concerns.

1.6 Whilst home visits were effective in supporting the most vulnerable families, the arrangements in Slough were not as effective when vulnerabilities were not clearly identified. The other community midwifery teams did not routinely offer home visits; there was an expectation that women would attend hospital and community clinics for ante-natal care. Health visitors offered ante-natal contacts to expectant mothers receiving additional support over and above universal services (known as universal plus or universal partnership plus). However, ante-natal contacts were not routinely offered to all expectant mothers. This limited the opportunities for the thorough assessment of holistic family health needs prior to birth and subsequent early intervention. ***Recommendation 1.3***. *We have brought this to the attention of the public health commissioners of the 0-19 service*.

1.7 A duty health visitor, school nurse and team leader carried out a triage function on all new referrals to the 0-19 service the same day they were received. This function applied to all children and families referred into the service from schools, GPs, other health practitioners, parents or children themselves. This ensured minimal delay in making decisions about how children and families could be best supported, either from within the service or through other local organisations.

1.8 The 0-19 service offered extra services that supported the identification of children and families with additional needs. This included additional services at weekends such as regular health visiting Saturday clinics and school nurses' attendance at Saturday school open days. There was also a reported good uptake of school nurse drop-in clinics in secondary schools. School nurses also undertook health questionnaires for all children in reception, year 6 and year 9. This increased the number of contacts with children and opportunities to consider early intervention.

1.9 Managers of the Slough early help service spoke positively of the engagement of the 0-19 service in providing targeted support for families and children. This included regular and active participation in team around the family (TAF) processes. This level of engagement with families was evident in health visiting records we reviewed.

1.10 Staff in the emergency department (ED) at WPH took part in regular, multi-disciplinary discussion. This supported them to take a holistic view of vulnerable children and young people and there were four such 'handover' meetings each day. The first of these was attended by a member of the trust's safeguarding children team, a substance misuse practitioner, an independent domestic abuse adviser (IDVA) and psychiatric liaison staff as well as the ED clinicians. This helped staff explore additional needs and risks alongside clinical needs.

1.11 Information sharing arrangements between the ED at WPH and universal health services were under-developed. The paediatric liaison health visitor was not always notified of attendances at the ED by all children and young people under 18 for onwards notification to the 0-19 service. Only children and young people who met certain criteria were notified in this way and so 0-19 staff were not able to consider the impact or relevance of the hospital attendance to all children they might have been supporting. ***Recommendation 1.4***.

1.12 Once engaged with services, children and young people in Slough with emotional health and wellbeing difficulties experienced child focused individualised support. However, some young people who needed further support could not easily get access into CAMHS. Whilst young people experienced swift triage at the point of access, there were some delays to initial assessment and then again until the commencement of treatment. There were long waiting times for some specialist services such as those for autism. The CAMHS had established a single on-line referral form and a pathway into a single point of access with a consultation and advice facility. This had gone some way to mitigate pressures. We acknowledge that these challenges were being tightly monitored by BHFT and the CCG.

Good practice example – children waiting to be seen by CAMHS

Where young people were on waiting lists for CAMHS services, each service operated a 'Care for Waiters' protocol where duty practitioners contacted the parent, carers and young person regularly to reassess risk, discuss and offer support and consultation. Children's cases were continuously evaluated and discussed in the multi-disciplinary team, enabling services to be focused on the highest level of need. This helped to mitigate the frustrations of families and helped the service to respond in a timely way should those needs escalate.

1.13 A well-established peri-natal mental health pathway was in place. This ensured that women who were not already being seen by the community mental health team received support for mental health difficulties through pregnancy and up to 12 months post-partum. The adult mental health service, the Crystal team and the perinatal mental health midwife who was based in the trust safeguarding team liaised closely. This helped women develop safer attachment with their new born babies and this was evident in some of our case examples. The attendance of the peri-natal mental health team leader at the maternity psycho-social meetings further facilitated identification and the early provision of support.

1.14 The Slough Treatment, Advice and Recovery (START) service carried out children's safeguarding assessments. The assessments considered a range of situational features to help staff understand the impact of a client's substance use on their parenting capacity. Records we looked at showed that this helped staff to develop a good understanding of children's needs. Staff routinely made referrals for all children identified in this way to the Children's Services Trust (children's social care) safeguarding front door.

Good practice example – Families where substance misuse was a feature

A dedicated 'whole family worker' in the START service supported clients who have children. The worker routinely attended TAF meetings and other safeguarding core groups to share information with other services and to contribute to planning. Close liaison between the whole family worker and social workers was evident in records we reviewed and this helped other professionals to understand the impact on families of substance misuse.

1.15 Young people attending the young person's sexual health clinic received a service that was responsive to their needs. A detailed safeguarding assessment, incorporating screening for exploitation, substance use and mental ill-health was completed for all those under 16-years and for those under 18-years where risk was suspected, and referrals were made when appropriate.

1.16 However, access to the young person's clinic was limited. There was just one such clinic at the sexual health hub in Slough each week and no outreach service for young people had been commissioned. This meant that most young people attended the all-age service at the Garden Clinic or visited their GP or local pharmacy for contraception. Although staff at the all-age clinic prioritised young people to ensure they were seen quickly, they did not always routinely have their holistic needs considered or risks explored using the safeguarding assessment. In addition, GPs who provided sexual health services to young people also did not routinely complete safeguarding assessments. There was risk that some children and young people in Slough with additional needs or risks would remain unidentified. ***Recommendation 3.1***.

1.17 School nurses provided sexual health advice through the drop-in service to schools in Slough and there was plentiful information available about services on the 'Berkshire Safe Sex' website. Despite this, the diverse population of Slough was not reflected in the population profile of those accessing the sexual health service. Young people from the large South Asian community in Slough were under-represented. Sexual health practitioners identified this as a risk but did not have the capacity to consult and work with community groups to either promote the service offer or to improve access for different groups. *We have brought both of these issues to the attention of the public health commissioners of the sexual health service*.

1.18 GPs generally contributed well to early help processes and shared information when required to do so. Although there were no formal assessment tools used in the practices we visited, risks to children and families, such as mental ill-health and domestic abuse were considered and noted in records.

1.19 Each GP practice had a named health visitor who co-ordinated information flows between the 0-19 service and the practice through vulnerable families meetings. This provided good local oversight of families receiving additional services and ensured that health needs of vulnerable children were properly and routinely considered and planned for. However, school nurses were not routinely invited to GP safeguarding meetings although school nurse leaders were working closely with local GPs to promote awareness of the school nursing offer.

2. Child in need

2.1 Midwives made routine enquiries about domestic abuse at booking appointments to increase the opportunities for identifying these risks. Flags on the electronic system prompted midwives to do this at subsequent appointments if it was not possible to ask at booking. Midwives also routinely asked all women about female genital mutilation (FGM). A disclosure or identified risk for either issue resulted in a referral to the Children's Services Trust which ensured that women, and their babies, received the right support as early as possible.

2.2 The identification of the impact of parental substance misuse on unborn and new born babies was underdeveloped in maternity. Although midwives were prompted to ask basis questions around smoking and alcohol, they did not routinely screen for alcohol disorders or consumption, which would support the identification of the risks of foetal alcohol syndrome. There was no evidence in maternity records of referrals to the substance misuse service, START, which midwives reported were often completed verbally. Although informal discussions had begun, there were no firm arrangements in place for the substance misuse team to participate in the weekly maternity psychosocial meetings. ***Recommendation 1.5***. *We have brought this issue to the attention of the public health commissioners of the substance misuse service.*

2.3 The assessment of additional needs in the maternity unit was further hampered by the many different record keeping systems. The effect of this was that record keeping was fragmented and this made effective safeguarding practice difficult. Of the records we were able to review, most lacked evidence of professional curiosity. Records were consistently parent-focused and did not capture well the voice of the unborn or newborn child. We have commented further on record keeping in child protection and leadership and management below. ***Recommendation 1.6***.

2.4 0-19 service staff regularly participated in children in need meetings and our review of records showed effective multi-agency collaboration with partners to achieve good outcomes for children. For example, one of the cases we reviewed demonstrated professional challenge, good analysis of risks and clear escalation of concerns to effectively safeguard the children. However, as we outline later, record keeping systems are a barrier to complete understanding of children's needs by the 'next practitioner'.

2.5 The Solutions 4 health practitioner who worked as part of the multi-agency safeguarding hub (MASH) performed a highly effective function for the partnership. Their research, sharing and interpretation of key health information and their participation in decision making for those cases where the risk was uncertain was an integral feature of the MASH. The effectiveness of this role, and the practitioner's recent contribution to the development of the partnership's work demonstrated the value of health services to safeguarding processes in Slough.

2.6 Children and young people attending the ED at WPH were well supported in a newly built, child friendly paediatric area. The separate children's waiting area enabled observation of the interaction between the child and the accompanying adult, as well as the identification of a deteriorating child.

2.7 During assessments, staff in the ED at WPH demonstrated good professional curiosity about children and young people attending the department, or those who were linked to adults attending. Staff considered those behaviours of adults that could put children at risk and this was evident in records we reviewed. This led to referrals being made, or information shared with named social workers where necessary.

2.8 This was not clearly demonstrated, however, for children potentially at risk of child sexual exploitation (CSE). We were advised that when such risks were suspected, children and young people would be transferred to the paediatric ward for a CSE assessment using an established, nationally recognised tool with support from the trust safeguarding team. We were not able to see any records where CSE was suspected so could not evaluate the effectiveness of this.

2.9 Children and young people admitted through the ED onto the children's ward with poor emotional or mental health did not always have their immediate safety assessed effectively. For example, the records of one of the children's cases we looked demonstrated a lack of robust environmental risk assessment, given their emotional vulnerability. This child was subsequently able to harm themselves whilst on the ward, although robust and effective planning was implemented immediately following the incident.

2.10 There was insufficient diligence by operational managers and practitioners in CAMHS in monitoring documentation relating to children in need. Our review of cases showed that child in need meeting minutes and plans from the Children's Services Trust were not actively chased to ensure they were SMART, could be promptly uploaded onto the case record and could inform day-to-day work with the child. ***Recommendation 2.1***.

2.11 Adult mental health practitioners were diligent and persistent in their efforts to engage adults experiencing mental ill health, particularly where there were children in the family. We saw evidence in case examples showing how practitioners successfully engaged patients to build trusting relationships and help to reduce risks of relapse or family breakdown.

2.12 The START substance misuse service issued secure storage boxes to all clients with children where they were prescribed medicines. Usage was monitored by staff and the process was audited so that case workers were assured that risks to children in their home from medicines were minimised.

2.13 Substance misuse staff followed strong processes for identifying and responding to safeguarding risks to children associated with their clients. The children's safeguarding assessment helped staff to identify any triggers to relapse and potential risks or impact to children arising from this.

2.14 Information sharing between the sexual health service and other health and social care services was variable and sometimes very limited. Records we reviewed demonstrated a lack of partnership working between the sexual health service and other services working with the same young people. For example, referrals were not made for young people to the substance misuse service. This did not support young people to have their needs met through a co-ordinated approach to their care.

2.15 Staff in the sexual health service did not consistently make routine enquiries about domestic abuse despite this being prompted in the female sexual health assessment. Men were not asked at all as the male assessment did not contain the prompt. This meant that children of adult service users, or young people in abusive relationships themselves, might not always be identified or safeguarded. Similarly, there was no routine enquiry into FGM in the female assessment. Women were only asked about FGM if they were from high-risk ethnic groups, and risks were often only identified at the point of fitting intra-uterine devices. Neither practice supports effective identification of children of service users who might be at risk. Furthermore, although some practitioners were professionally curious and proactive in referring all female children to children's social care if their relative had undergone FGM, this practice was variable. *We have brought both of these issues to the attention of the public health commissioners of the sexual health service*.

2.16 Although missed appointments were consistently monitored in GP practices, children and young people who were not brought to health appointments did not always receive robust follow-up from their GP. GPs were routinely informed of missed appointments with other health services, but follow-up with parents was variable between the practices we visited. ***Recommendation 3.2***.

3. Child protection

3.1 Generally, professionals from Slough's health services participated effectively in multi-agency child protection processes.

3.2 Midwives routinely made referrals to the MASH using the multi-agency referral form (MARF), which were copied to the named midwife. However, due to challenges in the fragmented record-keeping we have mentioned above, we were not able to review any referrals to assess their quality.

3.3 The most vulnerable pregnant women in Slough were discussed at weekly multi-agency psychosocial meetings as part of a clear, pan-Berkshire pre-birth pathway. Comprehensive minutes were shared by the chair. This supported good multi-agency decision making and oversight based on information from a range of sources.

3.4 A strong 'Think Family' approach was embedded in routine practice in the adult ED at WPH. All adults were routinely asked whether they had parental or caring responsibility or regular contact with children. Where the adult's presentation was a potential risk to children, such as mental ill-health, substance misuse or domestic abuse, safeguarding referrals were routinely made for the children although we have commented on the quality of these below.

3.5 Although staff in ED routinely made safeguarding referrals, the completion and quality of these was not always effective. Referrals were made on a bespoke form, and not the standard MARF used by other professionals in Slough. Referrals were frequently not fully completed by the referrer, with the trust safeguarding team adding missing information before submitting to the safeguarding front door. Most referrals we reviewed lacked any analysis of risk or clear description of impact for the child or young person. This means there was a risk of delay to children being properly assessed and of the referrer's concerns being inaccurately conveyed. ***Recommendation 1.7***.

Good practice example – Effective response to child protection concerns

A young child who had been brought to the ED by police was seen with extensive head injuries and admitted over night to assure their safety.

Staff at WPH made extensive detailed records of their actions including attempts to engage with the parents, a comprehensive risk assessment and a complete examination including body maps showing signs of historic, long standing abuse.

The strategy discussion was attended by the trust's safeguarding named nurse who appropriately challenged previous drift and delay of multi-agency work with the family.

The good practice displayed by a number of professionals across the hospital helped decisions to be made about how the child would be protected.

3.6 School nurses attended all initial and review child protection case conferences as well as presenting written information. They assessed the health needs of all children and young people either prior to or following the initial case conference. This is good practice as it enables other agency staff at core groups to take account of children's health needs with other aspects of child protection plans. We also noted there was a robust alerts system in children's electronic records in the 0-19 service. This supports the 'next practitioner' to quickly understand risks.

3.7 The 0-19 service had no mechanism to upload documents, such as safeguarding reports or meetings minutes, to the electronic records due to the limitations of the system. However, to ensure that records were as complete as possible, staff used another shared database for storing documents that was accessible to all staff. We saw some good, detailed and analytical examples of written reports for conferences held within and so we are assured of their quality and value to safeguarding processes.

3.8 BHFT operated a sound 'was not brought' policy across CAMHS with clear criteria prioritising action on children known to be most vulnerable; looked after children, children in need and those who are subject of a child protection plan. These children were discussed with managers and in a multi-disciplinary forum using a risk focused approach with appropriate actions taken promptly.

3.9 Our visit to CAMHS showed that lessons have been learnt in BHFT from cases which have not been effectively resolved through the escalation policy or which have taken protracted times to resolve. The escalation policy had been recently revised to ensure that multi-agency professionals' meetings were convened in a timely way to share information and concerns, to jointly evaluate risk and to ensure children with complex needs were safeguarded and supported effectively.

3.10 Referrals to the safeguarding front door that we reviewed in the CAMHS were overly descriptive and lacked evaluation and clear articulation of risk. The trust recognised this area for development, which was also identified in a recent safeguarding joint inspection in a neighbouring area. As a result, they had begun to put into place a quality assurance process with responsibility for oversight of referrals devolved to operational managers, which is good practice. In the meantime, the trust safeguarding team had begun a retrospective quality assurance and feedback process that was designed to build improvement over time.

3.11 There was a strong 'Think Child' approach in the adult mental health service where practitioners prioritised the safeguarding and protection of children in their day-to-day work. Staff demonstrated a clear understanding of their roles and responsibilities. We saw case examples of prompt and appropriate referrals into the MASH or to the Children's Services Trust when practitioners identified vulnerabilities or risks to children, including unborn children.

3.12 Where adult mental health and peri-natal mental health practitioners were invited to discharge planning meetings at maternity and could not attend, it was routine practice to telephone into the meeting and actively participate. This is good practice as it enables the meeting to be well informed by the practitioner likely to be best placed to assess parenting capacity.

Good practice example – participation in child protection procedures

The mother of an unborn baby had a long-standing history of engagement with mental health services. Despite a recent psychotic episode, she had refused to remain on medication so the peri-natal mental health midwife made a comprehensive safeguarding referral to the Children's Services Trust.

Good multi-agency liaison and discussion at the weekly maternity psychosocial meeting enabled professionals to be clear about risks and a pre-birth child protection conference was convened.

Effective information sharing by the peri-natal mental health practitioner and good supervision led to the conference being able to make a plan that set out clear actions and accountabilities across the relevant agencies. This was shared around the partnership within 24 hours of the conference taking place to enable all professionals to recognise escalating risks and to take appropriate action.

3.13 Generally, adult mental health practitioners routinely liaised directly with other professionals on individual cases and participated fully in child protection processes. This included providing good quality written information which had been effectively quality assured through supervision or peer review and attending the conference itself. This supported effective decision making by the conference where the mental health of adults was a feature.

Good practice example – identification of previous unreported risks

The START team were clear about potential risks to children of a client's substance misuse and made referrals to the safeguarding front door in each case.

For example, one client who used opiates had been supported by the service for some time. The person's recovery worker identified during discussion that the client actually lived with their family. This included a child, although the person had originally stated they had no access to children.

An immediate referral was made to the safeguarding front door. The referral was of a good standard and set out the risks of the client's substance misuse as well as the heightened risks in relation to the person's original denial.

3.14 Safeguarding practice and record keeping was inconsistent across the sexual health service. Records of some practitioners, specifically those who worked in the young person's service, demonstrated good professional curiosity and identified, assessed and responded to safeguarding risk well. However, professional curiosity, assessment and analysis of risk was not evident in all records reviewed. Some sexual health practitioners submitted referrals to the Children's Services Trust, the child sexual exploitation team or to CAMHS. There was no quality assurance of those referrals that were made and these were not stored on the young person's record, which meant we, too, could not assess their quality.

3.15 Although there were visible alerts for looked after children on the electronic patient records system used in the sexual health services, staff were not effectively engaged in child protection processes. Enquiries were not made of the service to determine if they were holding children who may be subject of conferences and so staff were not invited to contribute. In one case we looked at, a young person who was receiving regular support from the service and who was a looked after child had been effectively assessed using the safeguarding screen and this was updated at each three-monthly contact. No current concerns had been identified but staff were not informed that the person had had a mental health admission or that they had been subject of the Sexual Exploitation Multi-Agency Risk Assessment Conference (SEMRAC). This meant there was no opportunity to consider any previously unknown exploitation risks to this vulnerable young person. *We have brought this issue to the attention of the public health commissioners of the sexual health service*.

3.16 GPs in Slough contributed effectively to most multi-agency child protection processes. We saw evidence of referrals to children's social care, responses to MASH requests and reports to child protection conferences that were generally of a good standard. Minutes and plans from child protection conferences were shared with GPs. However, these minutes were not always attached to the records of all family members in one of the practices we visited; this is a gap in key information to assist care planning and the identification of risks. ***Recommendation 2.3***.

3.17 Both GP practices we visited had a system to record and monitor all vulnerable children on their caseloads, and information was reviewed and updated regularly. However, outcomes from strategy discussions and the results of information shared as a result of a MASH enquiry were not always noted on the patient records and were not followed up within GPs. This also means that key information about risks to a child might be overlooked. ***Recommendation 3.3***.

4. Looked after children

4.1 BHFT looked after children health team carried out the business processes associated with the health assessments of children and young people who were looked after by Slough council and other local authorities in the BHFT footprint. Initial health assessments were undertaken by community paediatricians at BHFT. Review health assessments for children under five and children of school age were carried out by health visitors and school nurses respectively from Solutions 4 Health. The specialist looked after children nurse carried out review health assessments for young people aged 16 and 17 and care leavers. There were equitable arrangements for assessing health needs of looked-after children placed in Slough by other local authorities as well as those placed outside the area by Slough council. BHFT had good understanding of this group of children and knew their health needs well.

4.2 Children and young people who were looked after by Slough local authority sometimes experienced delay in having their health needs identified and assessed within expected timescales. In the months preceding our inspection the proportion completed on time varied between 29% and 61%. In a small number of some cases this resulted in the child coming into care for a short time then exiting the care system without having an initial health assessment. This ongoing shortfall was identified on the BHFT risk register. The trust had submitted a business case to increase capacity in the looked after children health service thorough the provision of two additional clinics for initial health assessments each month and this was under consideration by commissioners at the time of our inspection. Partner agencies were closely monitoring the performance of the whole system through the Health of Looked After Children (HeLAC) operational group (see below under 'governance').

4.3 Looked after children's nurses had access to a variety of electronic records systems, enabling them to review relevant information about children and young people. This promotes effective information sharing and coordinated care for looked after children. For example, specialist nurses could access GP records so they had a holistic view of the child's health needs prior to them having their health assessment.

4.4 Immunisation history was routinely checked and included in health assessments. However, this good operational monitoring of immunisation history was not reflected in national performance data. Immunisations for Slough looked after children (39%) were significantly lower than England's average for the reporting period prior to this inspection. We were advised that this was due to a social care system data collection error and not representative of the actual picture where immunisations were routinely checked and arranged where needed, and this was in accord with our review of case files. Data collection about looked after children was under review at the time of our inspection but greater clarity was required to ensure the CCG, public health and the provider were assured of performance on immunisations. ***Recommendation 2.7***. *We have brought this to the attention of public health commissioners.*

4.5 In case records we reviewed, some sections of initial health assessments were incomplete, such as family information in the first section intended to be completed by social care. Staff did not routinely explore, or escalate those instances where information was missing from the initial documentation received from social care. In those cases, family composition was not captured consistently, and this does not support a complete analysis of risks or health needs arising from the family relationship. ***Recommendation 2.2***.

4.6 Initial health assessments did not reflect the child's voice well and it was difficult to get a good sense of the child's individual personality and character. In some health assessments for younger children the practitioner documented they were too young to contribute. Clinicians told us they conducted child focused consultations that reflected a good understanding of children's needs, including those of unaccompanied asylum-seeking children. However, this was not well evidenced in completed documentation. ***Recommendation 2.3***.

4.7 The voice of the child was stronger for older children in for review health assessments carried out by the 0-19 team and the specialist looked after children nurse. Developmentally age appropriate tools (visual faces) were incorporated into the assessment documents to allow children to express themselves and to share their wishes and feelings.

4.8 Looked after children referred to CAMHS did not receive a dedicated or discrete service but were automatically given a priority 'red' status and fast-tracked to initial assessment. Although they were then placed on the same waiting list as other young people, they remained risk rated as 'red' until the commencement of treatment and were placed at the head of the waiting list for community CAMHS services. Thereafter, priority was allocated on the on the basis of the level and immediacy of clinical risk. However, this did not always result in looked after children receiving a prioritised service. In one case we reviewed of an unaccompanied asylum-seeking child, a referral made to CAMHS twelve months prior to our inspection had still not resulted in the young person receiving therapeutic support. ***Recommendation 4.1***.

4.9 Looked after children or care leavers who were pregnant were referred to the Crystal team. Good practice was evident in one case we reviewed where a care leaver was referred to the team despite there being no additional obvious safeguarding concerns other than the fact that the young person was a care leaver. This means that this group of young people benefitted from the enhanced service for vulnerable mothers.

4.10 Slough council were looking after a small number of unaccompanied asylum-seeking children at the time of our inspection. Although the paediatricians and the specialist looked after children nurse had undertaken training on the lived experience of these children this was not well evidenced in their initial health assessments that we reviewed. This does not support a good understanding of health needs, particularly emotional health needs, arising from their experience or their journey to the UK. ***Recommendation 2.4***.

4.11 We saw that strengths and difficulties questionnaires (SDQ) were used for children and young people between four and 16, completed by social workers then shared with the health team. However, in some records we looked at the SDQ was not evident and so did not feature in the health plan. Opportunities for them to use these within their health review to map their own emotional growth and changes over time were lost. The provision of SDQs to the health team had been highlighted as a concern with the Children's Services Trust and was being monitored at operational health meetings.

4.12 Health action plans were mostly SMART and outcome focussed. Referrals to other services happened in a timely manner ensuring the child's needs were met effectively and health action plans were routinely shared with GPs. This promotes continuity of care.

4.13 The review health assessment documentation included evidence that previous health plan recommendations had been considered during the assessment, although previous recommendations were not always reflected in the summary of the health assessment. In our discussions during the inspection, staff agreed that this would support a clear, continuing picture of the way a child's health needs were being met on their journey through care. ***Recommendation 2.5***.

4.14 There was a sound quality assurance process in place for review health assessments undertaken by the specialist nurse using criteria based on national guidance. A health quality summary was completed and shared with social care and GPs. This provided opportunities to identify areas of good practice and areas for improvement at an operational level.

4.15 Quality assurance of individual initial health assessments was less well developed. At the time of our inspection, the quality of initial health assessments was checked through an annual quality audit across the BHFT footprint rather than routine, prompt scrutiny following each assessment. This reduces opportunities for dynamic practice improvement. ***Recommendation 2.6***.

4.16 The health offer to care leavers was good including the provision of a health passport. The looked after children health service was commissioned to support young people up to the age of 18 but in a few cases where specific needs were identified, the specialist nurse retained contact and involvement beyond 18 where possible. This complemented the local authority's offer to support care leavers to the age of 25 and to provide each young person with a personal advisor to support transition to adulthood.

4.17 Young people we spoke with during the review said they knew and liked the looked after children nurse, as she had attended their group sessions to gain an understanding of their views and ideas about how to improve the service offer.

4.18 Young people felt they could be given more choice about the timing and conduct of their health assessments. Most said they would like more choice of where they had their health assessment. Most young people also said that they were embarrassed at having health appointments with the foster carer.

4.19 Most young people we spoke with had mixed views about the time that elapsed between receiving their appointment notification and actually attending to have their review health assessment. Some young people said they had no notice and some said they had found out the day before. Some felt it would have been useful beforehand to have a briefing about the questions they would be asked. One young person felt the questions were overwhelming, especially as they were trying to process what was happening. As a result, they said they shut down and did not share how they were feeling emotionally. They explained that this was why they had stopped having their review health assessments ***Recommendation 5.1***.

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 Health leadership have been active with local partners as co-producers in the development of local processes for safeguarding. For example, the value of the continued contribution of health leaders to the development of safeguarding information flows in the front door and MASH was acknowledged by local authority and partnership leaders we spoke with. This has strengthened the role of health in the management of individual cases, particularly in the MASH, where we observed good exchange and analysis of health information, and a valued contribution being made to decision making.

5.1.2 There was visible and supportive safeguarding leadership to health provider safeguarding teams by the designated nurse and designated doctor. The relationship was a proactive one with quarterly data reporting and safeguarding group meetings. This has created a framework for responsive and dynamic improvement activity as we saw evidenced through the week of our inspection.

5.1.3 There was effective leadership and accountability within BHFT's specialist looked after children health team. Leaders in the service were child focused in their practice. The service was open to learning and continuous improvement and had made use of learning from the CQC's report into previous CLAS reviews (Not Seen Not Heard) in developing the service. During our visit to the service we were encouraged to see that feedback given throughout our visit was acted on promptly.

5.1.4 The looked after children service benefitted from having a very experienced specialist nurse. The nurse engaged well with other professionals and forums, such as the SEMRAC, and took a proactive approach to developing the service. This included work with the virtual head to ensure review health assessments were appropriate for looked after children who also had an education health and care plan.

5.1.5 For FHFT, we should acknowledge that the trust was working to improve the high vacancy rates and excessive caseloads of midwives as identified in the most recent CQC inspection of the trust. Leaders were aware of the impact of this on safeguarding practice and recruitment was ongoing at the time of our review.

5.1.6 Maternity keeping systems and processes in WPH were fragmented. As well as 'hand-held' notes, documentation was held in a further five places and not all documents could be accessed by all midwives. Apart from restricting our review of cases, this did not support the trust's own assurance into safeguarding practice.

5.1.7 The named midwife role in WPH was not part of the trust's safeguarding team and this limited the impact of strategic direction on operational safeguarding practice, for example, the practice in relation to 'Think family' we reported above.

5.1.8 Leaders in the 0-19 service acknowledged that health visitor caseloads were too high due to their capacity at the time of our inspection and this featured on the Solutions 4 Health risk register. Increased caseloads had impacted on the delivery of the healthy child programme for children and families living in Slough although skill-mix teams had received additional competency-based training to support some of the universal service delivery.

5.1.9 The record keeping system in use in the 0-19 service did not support effective safeguarding practice and the understanding of risks by the 'next practitioner'. Staff could not attach additional documents to electronic records, including child protection conference minutes and plans. In some cases, summaries were made in the child's electronic health record but this practice varied. We were pleased to see the practice of locking a record when a child moved out of area had stopped as a result of our feedback to the service during our inspection.

5.1.10 An audit of records in the 0-19 service by the safeguarding team was responded to positively by Solutions 4 Health. Additional training in record keeping, particularly in relation to capturing the child's voice, had resulted in an improvement in the quality of this in records that we identified during the week. However, referrals to the Children's Services Trust were not audited, which means there was no assurance of effective practice in this area. *We have brought these foregoing issues to the attention of the public health commissioners of the 0-19 service.*

5.1.11 The staff in the ED and children's ward at WPH benefitted from strong, visible leadership and support from the safeguarding team and the named nurse. The safeguarding team had good oversight of referrals made to the safeguarding front door and we saw evidence of quality improvement as a result of audit activity. However, as we have identified above in 'child protection' there is still work to do to improve the consistency and quality of referrals.

5.1.12 At the time of the inspection staff in the ED were unable to access the Child Protection Information Sharing (CPIS) system, despite Slough children's social care and the trust having signed up to it. The assurance of whether children and young people were known to the system relied on the clinician having concerns and requesting the safeguarding team check CPIS on their behalf. This caused delay and the limited use of the programme defeated its object. ***Recommendation 1.8***.

5.1.13 Commissioners and BHFT were working in partnership to address the issues in relation to access into CAMHS in the long-term. Together they were progressing a range of short-term initiatives to address the access problems that were prevalent at the time. For example, the CAMHS rapid response team was using additional resources to undertake short-term interventions with young people with the highest levels of need and recruitment into the team was in hand.

5.1.14 Management restructuring in CAMHS had created a temporary pause in this development work due to recruitment and capacity pressures. As a result, operational leadership and practice oversight was not currently as strong as it needed to be as evidenced in our review of cases during the week and reported in 'child in need' above. The trust was aware of the need to strengthen management governance and oversight of practice. ***Recommendation 2.2***.

5.1.15 Additional investment and initiatives, such as the setting up of the complex case panel for children and young people within CAMHS to facilitate complex and high-risk cases that have become 'stuck' also supported increased throughput to increase capacity within CAMHS. This was a positive development based on the successful risk panels established and operating well in adult mental health.

5.1.16 BHFT were well represented at the Multi-agency risk assessment conference (MARAC) with an effective system of information sharing in place across the trust's services.

5.1.17 Managers in the adult mental health service did not have a clear understanding and picture of the profile of vulnerable children, children in need and child protection cases in the service across their adult client caseloads. Some case records we looked at clearly set out details of children, with names and dates of birth whereas others did not, with family composition only becoming clear on scrutiny of progress notes. This limited insight into families does not support targeted supervision and could lead to risks remaining unidentified. ***Recommendation 2.8***.

5.1.18 Adult mental health service managers demonstrated evidence of learning from serious incidents. For example, although there had been a long-standing involvement of adult mental health in the Wexham Park maternity psychosocial meetings, participation and engagement had been strengthened as the result of learning from a serious incident.

5.1.19 The START substance misuse service had a dedicated safeguarding lead staff member who monitored and co-ordinated all safeguarding activity for the service by way of a safeguarding log. This tracking tool was updated weekly and provided robust oversight of safeguarding activity. This was enhanced by a range of routine audits, such as regular safeguarding case file audits and a central audit of a random sample of records by the provider's quality and risk lead.

5.1.20 The sexual health service did not have direct representation at multi-agency meetings such as the SEMRAC, FGM progression group or PAUSE[1] operational meetings. Although the trust safeguarding team attended the SEMRAC meetings there was no assurance that the service received feedback from these meetings to support their practice with individual young service users. *We have brought this issue to the attention of the public health commissioners of this service.*

[1] PAUSE is a multi-disciplinary programme run by the local authority to support women at risk of repeated pregnancies resulting in children removed from their care.

5.1.21 The named GPs had been instrumental in developing effective safeguarding systems in GP practices across Slough through visible and proactive leadership. Safeguarding practice was generally well-developed. There was good use of alerts and flags on the electronic patient records system and consistent arrangements for sharing information with other health disciplines. However, as we have already reported above, there was some variability in sharing and storing safeguarding documentation and in completing safeguarding assessments.

5.2 Governance

5.2.1 Leaders from the CCG, public health commissioners and health providers were strong and active partners in the current local safeguarding governance arrangements (which was still a safeguarding children board at the time of the inspection but which has now transitioned to a safeguarding children partnership). For example, public health commissioners had been key influencers in the board's neglect strategy.

5.2.2 In addition, the Head of Safeguarding from BHFT chaired the board's training sub-group with named professionals representing the trust on the board's sub-groups. FHFT were also key partners in multi-agency strategic groups with representation by the named nurse on the safeguarding board and its sub-groups.

5.2.3 There were mature, strategic partnership relationships where good dialogue had led to a responsive and learning culture at executive level. For example, our inspection activity in health services demonstrated how lessons learned from serious case reviews, learning reviews and previous inspections had influenced frontline practice through effective strategic direction.

5.2.4 The partnership was making positive progress on developing a robust multi-agency governance infrastructure to ensure effective monitoring and governance of the health of looked after children. A monthly, operationally facing Health of looked-after children group (HeLAC) had been set up to address identified performance areas needing improvement. This group was developing a multi-agency action plan to improve the timeliness of initial health assessments, ensure data was shared effectively and oversee the implementation of a governance process for health assessments. As a result, the partnership had begun to strengthen its understanding and scrutiny of what contributed to poor performance and agencies were taking responsibility for resolving their part of the issue. For example, the local authority had begun to ensure looked after children notifications were submitted promptly to the health team although it was too early to measure the impact of this.

5.2.5 Overall, the annual report for the health of looked after children for 2017-18 for the boroughs, including Slough, represented a comprehensive summary of performance and compared performance across the Berkshire boroughs well. There was scope for the report to better support continuous service improvement and better outcomes for looked after children. While there were priority areas of work set out at the end of the report, these were not clearly drawn from those identified under the different sections of the report.

5.2.6 Both FHFT and BHFT have large footprints covering a number of local authority areas in Berkshire and beyond. The annual safeguarding reports for both trusts outline safeguarding performance for the trusts as a whole (for the individual hospitals in the case of FHFT) and do not disaggregate between Slough and neighbouring authority areas. Any local performance issues specific to Slough were not highlighted.

5.2.7 Nonetheless, both trusts had effective safeguarding governance structures with a clear line of accountability to the trust boards through an executive lead. Both trusts have well-established safeguarding teams with named professionals accountable for operational practice and structurally aligned with geographical areas.

5.2.8 The report for FHFT acknowledged the amount of time spent by the safeguarding team in editing and adding missing information to referral forms before they could be sent to the local authority and that quality of referrals was an area for improvement. However, this was not identified as a priority at the conclusion of the report. As we have recommended following our review of cases, this remains a priority area of work for FHFT.

5.2.9 The contribution of Solutions 4 Health to the Slough Safeguarding Children Board annual report for 2017-18 was very brief and did not report any meaningful or measured information about the provider's safeguarding performance. Its use as a benchmarking tool to assess future performance was limited. We acknowledge, though, that the shortened template provided by the board for this purpose at the time simply required the provider to summarise the more detailed reports they sent to commissioners and partners each quarter. The provider's safeguarding practice audit over the summer 2018 was more relevant, despite the relatively small sample size. The audit described a much more candid picture of performance over a number of areas, which were used to drive improvement, such as in relation to record keeping, the child's voice and conducting challenging safeguarding conversations. We noted that record keeping, in particular, was an improving picture despite the limitations of the electronic patient records system as commented on above.

5.2.10 The looked after children health team had a close working relationship with the designated nurse. Commissioners gained assurance about the service through a range of regular meetings at both strategic and operational level, and the submission of quarterly reports. Commissioners had good insight into clinical practice in the looked after children service.

5.2.11 There were effective overarching governance and communication structures in the Solutions 4 Health 0-19 service. Safeguarding was integrated into all operational and strategic meetings. Safeguarding data was collated using a variety of different methods, such as team leader meetings, safeguarding supervision and the school nurse dashboard and this ensured leaders were generally well sighted on safeguarding performance.

5.2.12 Mandatory attendance at monthly team meetings and case management meetings supported good communication with 0-19 practitioners. There was mostly effective operational oversight of risks within families. However, in a small number of school nursing case records, some examples of delay and drift indicated that there was still work to do to ensure consistency.

5.2.13 BHFT engaged successfully with children and young people to improve the looked after children service. For example, BHFT produced a quarterly 'You said, we did' briefing for young people and the specialist looked after children nurse routinely attended REACH (the Children in Care Council in Slough). Young people's feedback was considered and discussed at monthly team meetings. This had led to the co-production of a care passport, which were routinely handed to young people at their last review health assessment. These passports supported care leavers to make independent decisions about their health.

5.2.14 CAMHS was developing services in an increasingly co-productive way, with young people participating from the earliest stage. For example, young people expressed a preference for a discrete and separate resource to support them with their emotional wellbeing and this resulted in the development of an on-line resource.

5.2.15 Partners recognise that the current waiting times for neurodevelopmental services is unacceptable; in excess of 22 months for autism and 12 months for ADHD. The CCG is putting in additional resource to address the front door pressure and has commissioned an external review of the pathway. This was with commissioners for their consideration at the time of the inspection so we cannot assess whether this would lead to improvements.

5.2.16 The oversight of safeguarding practice in the substance misuse service was enhanced by a range of routine audits. For example, the service manager carried out regular safeguarding case file audits so that one client file for each recovery worker was audited each month for quality and completeness with a corresponding action plan to enable the practitioner to improve practice. In addition, the provider's quality and risk lead carried out safeguarding case file audits on a random sample of safeguarding cases and produced an action plan for the service to rectify any shortfalls. We reviewed the information for the last three audits which showed that the safeguarding performance of the Slough service was effective as compared with other locations and this was also evident in our review of cases.

5.3 Training and supervision

5.3.1 Training a supervision was variable across Slough but most services had a well-trained and competent workforce.

5.3.2 Looked after children practitioners had received level four safeguarding training (according to the intercollegiate guidance on safeguarding competencies), including access to a range of multiagency training. Practitioners had access to regular safeguarding supervision with an expectation to attend four group sessions annually. One-to-one safeguarding supervision was also available when required with open access to the trust's safeguarding team.

5.3.3 All midwives had complete level three safeguarding training with additional competencies for specialist roles. Midwives working with the most vulnerable women and families in the Crystal Team in WPH, benefitted from monthly one-to-one safeguarding supervision. This was reflective and restorative, documented by the supervisor and centrally stored. However, as records of supervision were not documented in women's records in line with best practice, we were unable to review to assess the quality. ***Recommendation 1.9***.

5.3.4 All 0-19 service team members that worked directly with children had received level three safeguarding training with consistently high compliance rates reported over time. Practitioners had access to a range of multi-agency training that covered a range of different topics including FGM and exploitation through 'county lines'. Agency staff and new starters had a robust induction programme that included safeguarding competencies. Safeguarding training was completed within two weeks of joining the organisation which indicated the importance placed upon this skill set.

5.3.5 Supervision arrangements within Solutions 4 health were robust. Practitioners received regular supervision from managers every four to six weeks with safeguarding supervision by the named nurses every three months. Advice and guidance was also available as and when required. The named nurses received regular safeguarding supervision from the CCG designated nurse. Practitioners were responsible for recording the outcome of supervision within health records although this was not consistently evident in case reviewed. Staff told us they felt well supported by managers. For example, team leaders were also on call on Saturdays during clinic times to support staff with concerns or safeguarding issues.

5.3.6 All nursing staff working in the children's ED were qualified children's nurses, and all had either completed or were booked to attend advanced paediatric life support (APLS) training. Staff working in the ED however, had not all received the relevant level of safeguarding training, with compliance being significantly below the trust target. All qualified staff and nursery nurses in the children's ED, and consultants in the adults' ED were booked to attend a full day's multi-agency training to meet this shortfall. In the meantime, the trust safeguarding team were providing weekly 'mop-up' sessions in the ED for staff whilst awaiting the formal sessions. ***Recommendation 1.10***.

5.3.7 Safeguarding supervision for staff working in the children's ED and ward at Wexham Park Hospital was available in a group format on a monthly basis with one-to-one supervision available on request of the individual practitioner. Supervision was restorative and reflective which supports staff to learn and to manage their feelings in relation to safeguarding incidents.

5.3.8 Training on child safeguarding in CAMHS was appropriate at level three with good reported compliance rates. Adult mental health practitioners, however, did not receive child safeguarding training at a sufficient level to properly support them in their day-to-day practice given the complexity of the cases they were working with. BHFT policy was for adult practitioners to undertake level two safeguarding training, including the peri-natal mental health team; this is insufficient. This was a priority area for development although we acknowledge the trust were aware of and were working to resolve this, including providing two-hour seminars to all staff on the voice of the child whilst staff awaited formal training. ***Recommendation 2.9***.

5.3.9 There was good supervision, including for safeguarding, across BHFT adult mental health and CAMHS. This comprised group supervision provided by the trust's safeguarding team and an accessible and supportive individual supervision offer. We are aware the trust was working to increase the frequency of safeguarding supervision to reflect the needs of the service.

5.3.10 Staff in the START service workforce were knowledgeable about safeguarding and understood local processes. All staff received training to the equivalent of level one and level two during their induction and this was refreshed every three years. This was supported by a safeguarding competence-based programme during induction. Existing staff were being required to update their skills through a similar programme to ensure they remained competent to identify and respond to risks to children associated with their clients.

5.3.11 The safeguarding supervision offer for staff in the START service was comprehensive, comprising four to six, weekly, one-to-one case-based supervision sessions and monthly restorative group supervision. The strength of safeguarding practice as a result of this was borne out in our review of records.

5.3.12 The safeguarding lead in the BHFT sexual health service chaired a monthly safeguarding review meeting to discuss cases of interest and concern and share learning. External speakers were also invited to some meetings to update staff on specific safeguarding issues such as 'county lines'. All staff in the service were encouraged to participate including receptionists, but attendance was variable.

5.3.13 Although staff in the sexual health service had received sufficient training at level three, supervision was limited. Safeguarding supervision was offered to the safeguarding lead doctor on a quarterly basis, but this was not case specific. Safeguarding supervision was not offered at all to any other clinician and this was a gap.

5.3.14 Receptionists in the sexual health service received level one training just once. This could be strengthened in the same way as for reception staff in primary care as receptionists are often key to the early identification of risks in clients who arrive at the service. *We have brought these issues to the attention of the public health commissioners of the sexual health service.*

5.3.15 All staff in both GP practices we visited had received level three safeguarding children training. In addition, all administrative and reception staff received level two in accordance with newly issued guidance. GPs also attend six-monthly learning events within the CCG to share good practice and this strengthens joint working and a co-ordinated approach to safeguarding.

5.3.16 There were no formal arrangements for safeguarding supervision for staff in GP practices although advice and guidance was sought upon request from the named GP, designated nurse and the safeguarding team in the acute trust. This offer was reportedly frequently taken up although we were not able to see evidence of case discussion in records.

Recommendations

1. Frimley Health NHS Foundation Trust should:

1.1 Implement effective assessment tools to support midwives to explore risks arising from social history, family composition or adverse childhood experiences and to capture full details of partners, fathers and other children.

1.2 Reinforce the use of the targeted ante-natal form to ensure full information and effective analysis of risks is shared when making referrals about vulnerable families to health visitors.

1.3 Strengthen the criteria for offering ante-natal home visits to pregnant women to increase opportunities to identify and assess for additional needs for women and unborn children that would benefit from early intervention.

1.4 Develop the arrangements for sharing information about children who attend the ED with the 0-19 service.

1.5 Work with Turning Point to develop a formal mechanism for making referrals to, and sharing information with, the substance misuse service.

1.6 Rationalise the record keeping systems in use in maternity to ensure risks and additional needs can be readily identified and recorded and can provide assurance in relation to safeguarding practice.

1.7 Improve the consistency and quality of safeguarding referrals made to the safeguarding front door.

1.8 Implement the use of the CPIS system in ED.

1.9 Record safeguarding supervision with midwives in the patient record in line with best practice to ensure a good audit trail of the rationale for decisions.

1.10 Provide adequate level three training for staff in the ED at Wexham Park Hospital.

2. Berkshire Healthcare NHS Foundation Trust should:

2.1 Develop processes and understanding of CAMHS staff, including management oversight, to ensure records from child in need procedures are fully uploaded to case records to inform day-to-day planning and care.

2.2 Record details of family composition fully in initial health assessments for looked after children to enable a full understanding of risks or health needs and escalate those instances when full information is not received within notification documentation.

2.3 Improve the quality of recording of the child's voice in initial health assessments so it is clear that the child's wishes and feelings have contributed to their health plan.

2.4 Develop the practice of obtaining the experiences of unaccompanied asylum-seeking children who are looked after to better understand their health needs.

2.5 Ensure that health assessment summaries include information about the review of previous looked after children health action plans.

2.6 Improve the quality assurance process for initial health assessments of looked after children.

2.7 Work with the local authority to improve the assurance process for immunisation data about looked after children.

2.8 Increase management oversight of records in the adult mental health service to ensure staff record and take account of children associated with adult clients.

2.9 Provide level three safeguarding training for staff in adult mental health teams.

3. NHS East Berkshire CCG should:

3.1 Develop the use, by GPs, of a safeguarding assessment for young people attending for a sexual health consultation to ensure additional needs or risks are identified.

3.2 Improve the follow-up by GPs of children not brought to health appointments.

3.3 Improve, and standardise, the system for managing safeguarding information in GP practices to ensure that there are no gaps in information that would support care planning or the identification of risk.

4. NHS East Berkshire CCG and Berkshire Healthcare NHS Foundation Trust should:

4.1 Implement a process that ensures the emotional wellbeing and mental health needs of looked after children are prioritised in recognition of their particular vulnerabilities.

5. Berkshire Healthcare NHS Foundation Trust and Solutions 4 Health should:

5.1 Provide looked after children and young people with the opportunities to make more choices about the timing and conduct of the health assessments. This should include whom should be present, where the assessment takes place and how much information they are provided with in advance about the question they will be asked.

Next steps

An action plan addressing the recommendations above is required from NHS East Berkshire CCG, within **20 working days** of receipt of this final 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.