Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in South Gloucestershire Council

Date of Inspection	**25th June 2012 - 6th July 2012**
Date of final Report	**10th August 2012**
Commissioning PCT	**NHS South Gloucestershire, part of the Bristol, North Somerset and South Gloucestershire cluster (BNSSG)** **NHS Bristol for NBT and UHB**
CQC Inspector name	**Jan Clark**
Provider Services Included:	**Frenchay Hospital, North Bristol NHS Trust (NBT)** **Southmead Hospital** **Bristol Royal Hospital for Children, University Hospitals Bristol NHS Foundation Trust (UHB)** **Avon and Wiltshire Mental Health Partnership NHS Trust** **Sirona**
CQC Region	**South (West)**
CQC Regional Deputy Director	**Ian Biggs**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report .

South Gloucestershire Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	ADEQUATE
Capacity for improvement	ADEQUATE
The contribution of health agencies to keeping children and young people safe	ADEQUATE
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	ADEQUATE
Capacity for improvement of the council and its partners	INADEQUATE
Being Healthy	ADEQUATE

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's head of national Inspections, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

South Gloucestershire has a resident population of approximately 63,300 children and young people aged 0 to 18, representing about 25% of the total population of the area. In 2011, ten percent of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall and 3.5% of pupils are of mixed heritage background. Some 4% of pupils speak English as an additional language with Polish and Punjabi being the most recorded commonly spoken community languages.

The long-established South Gloucestershire Children and Young People's Strategic Partnership became the South Gloucestershire Children's Trust in 2010. The trust includes representatives of South Gloucestershire council and primary care trust. Other representatives include Avon and Somerset Police, Avon Probation, North Bristol NHS Trust, church authorities, the voluntary sector and representatives of local schools and colleges. The South Gloucestershire Safeguarding Children Board became independently chaired in September 2010, bringing together the main organisations working with children, young people and families that provide safeguarding services. There are no local authority children's homes. External provision is commissioned from 15 residential and special schools.

Social care duty, assessment and intervention functions are delivered by two locality based teams established in September 2011. These are based in the north and south; other social care functions are supported by centralised teams for looked after children/care leavers, children with a disability, youth offending, adoption and fostering. There is an emergency out of hours service. Other family support services are delivered through 15 children's centres and a locality based family support service. Some services are also provided or coordinated through children's services, such as youth services, teenage pregnancy, Connexions and drugs & alcohol support.

At the time of the inspection there were 211 looked after children. They comprise 49 children under five years of age, 135 children of school age (5–16), 27 post-16 young people and a total of 143 with care leaver status. At the time of the inspection there were 212 children who were the subject of a child protection plan. This is an increase over the previous two years. These comprise 85 females and 121 males (six were unborn children). Some 37.9% of these children are aged under five, 40.8% are 5-11 and 21.3% are 12 years or older. The highest categories of registration were emotional abuse at 53.3%, neglect at 31.6%, physical abuse at 9.4% and sexual abuse at 5.7%.

Commissioning and planning of national health services and primary care are carried out by NHS South Gloucestershire, part of the Bristol, North Somerset and South Gloucestershire (BNSSG) PCT Cluster. The main providers of acute hospital services are North Bristol NHS Trust (NBT) at Frenchay Hospital in South Gloucestershire and University Hospitals Bristol Foundation NHS Trust (UHB) at Bristol Royal Hospital for Children in Bristol, which sees the majority of emergency paediatric activity in the wider Bristol area. Maternity and newborn services are provided by both NBT and UHB. In addition, some patients in the east of South Gloucestershire access maternity and services at Royal United Hospitals Bath NHS Trust. Children and families access primary care services through one of 29 GP Practices. There are no walk in centres located in South Gloucestershire. There is a Minor Injuries Service at Yate, operated by NBT.

Universal services such as health visiting and school nursing are delivered by a partnership between North Bristol NHS Trust (NBT) and Barnardos, known as the Community Children's Health Partnership (CCHP). This Partnership provides services across South Gloucestershire and Bristol. Community children's health services, including child and adolescent mental health services (CAMHS), services for children with physical and learning disabilities and those who have complex health needs are provided by the CCHP within NBT/Barnardos. Specialist community nursing services for children and young people with life limiting or life threatening conditions are provided by Sirona, a social enterprise which was previously part of NHS Bath and North East Somerset.

A small number of services are jointly commissioned by the NHS and the council. The young people's drug and alcohol service and the youth offending service are jointly commissioned using a pooled budget. Child and adolescent mental health services (CAMHS) are jointly commissioned using aligned budgets. South Gloucestershire contains three secure establishments for young people. Vinney Green Secure Unit is a local authority secure children's home operated by the council. Responsibility for commissioning health services at secure children's homes transferred to the NHS on 1st April 2012. Some services, e.g. psychiatry and substance misuse are provided by the NHS and others are provided by the private sector. HMP/YOI Ashfield is a private prison operated by Serco. As a private prison Ashfield commissions and provides the majority of its health services. The CAMHS and specialist substance misuse services are however commissioned and provided by the NHS, with the provider being NBT. HMP/YOI Eastwood Park has a juvenile unit, the Mary Carpenter Unit and several NHS and non NHS providers providing health services, including Hanham Health and NBT.

South Gloucestershire's designated doctor and operationally focused nurse for looked after children, and the designated doctor for safeguarding are hosted by NBT. Within NHS South Gloucestershire the director for quality and governance in the BNSSG Cluster has executive responsibility for safeguarding, and manages the designated nurse for safeguarding post. This latter role also includes strategic designated nurse responsibilities for looked after children.

Within the BNSSG Cluster and across the former NHS South West area the PCTs operate lead commissioning arrangements. NHS Bristol is the lead commissioner for NBT and UHB. NHS Bath and North East Somerset is the lead commissioner for RUH and Sirona. NHS South Gloucestershire is the lead commissioner for Avon and Wiltshire Mental Health Partnership NHS Trust.

General – leadership and management

1 The council, health and other partners have a clear strategic direction as set out in the Partnership Strategy for Children and Young People 2012-2016. The children's trust and local safeguarding children's board (LSCB) have successfully addressed weaknesses in relation to the understanding and implementation of thresholds, the use and impact of the common assessment framework (CAF) and the effectiveness of early intervention. These had been previously identified in a serious case review (SCR) and two unannounced Ofsted inspections.

2 A number of key partnership milestones have been reached which includes the formation of co-located health, preventative and social work hubs newly in place. This, alongside work on the use and impact of CAF, has improved early intervention and step down services, knowledge and understanding of thresholds and improved joint 'Team Around the Child' working. In addition, work has successfully been undertaken by the council and partners through the LSCB to address the lack of involvement of general practitioners in case conferences. Shared plans with the council for a single point of contact to be created, known as 'First Point' demonstrate positive and clear shared ambition.

3 Health's contribution to safeguarding is adequate with the overall effectiveness of safeguarding arrangements also being adequate. Safeguarding standards are embedded in health provider contracts, strengthening accountability for safeguarding service delivery and subject to effective governance through the PCT and LSCB. In addition to the lessons learnt from SCRs being addressed, areas for development identified by the child death overview panel (CDOP) are also informing practice improvement. The designated doctor and designated nurse provide appropriate leadership, supervision and support to safeguarding leads whilst setting clear expectations and monitoring providers closely. The designated nurse for safeguarding is retiring and a new appointee from another area is about to take up post. Named safeguarding professionals within provider services are accessible and seen as a valuable source of advice and guidance to most front line staff.

4 The delivery of health care to looked after children is adequate. Performance on the undertaking of initial health assessments within the expected 28 days of young people becoming accommodated has historically been poor and remains a challenging area for the partnership. The looked after children health team recognised that children might be entering and leaving care without having a comprehensive health assessment and have taken action to deliver improvements. A fully developed, whole system approach across the health and social care partnership to ensure good quality, timely healthcare provision for all looked after children, including those placed out of area, is not in place. The designated doctor and the looked after children nurse meet fortnightly and have put systems in place that will facilitate improved performance, enabling them to focus on other areas for development.

Outcome 1 Involving Users

5 Health records do not evidence strong young people's participation in health assessments and reviews. Records do not evidence that older young people are given a choice about having a private discussion to review their health with the looked after children nurse separate from their foster carer. A lack of choice could inhibit open discussion about sexual health, smoking or drinking, for example. However, young people like the looked after children nurse and feel well supported by her.

6 Young people are also not given any documentation from their health assessment although the development of a health information personal folder is positive. The looked after children health team are working with the Barnardos participation worker to explore the development of an age appropriate letter which the young person can take away. It is not clear from health records what health promotion material young people receive at their health assessment, although young people have told us that they do receive useful information. Health chronologies are not developed routinely as part of the looked after children health record with only one seen on the case sample. This does not facilitate the development of health histories for care leavers.

7 The provision of health information and support to care leavers has been identified by the looked after children health team as an area for development. Care leavers do not currently get a health history or letter. They are given their immunisation record and can re-engage with the looked after children nurse up to the age of 21 years. Engagement with the CICC is in development. The Barnardos' participation worker is seeking feed back from the CICC about their experience of healthcare as looked after children. The CICC have an annual slot to feedback to the corporate parenting board but there is scope to strengthen this engagement. While the pledge 'Our Promises' contains health elements it is not clear how young people are able to hold health and social care to account for these.

8 The structure of support arrangements for care leavers is changing. Although consultation with young people is still underway, staff and looked after young people told inspectors that they are already seeing benefits in improved communications through leaving care services being placed in a 'Youth Hub'. Young people like the access to a mix of expertise in housing, health, budgeting and careers guidance that is available. Partnerships between housing, social care, education providers, Connexions and health are very strong and focused on improving the outcomes for care leavers. Care leavers report being able to access a wide range of personal support for health and housing.

9 The participation of young people in aspects of service development and delivery is positive. Young people using CAMHS services participate in the regular multi-agency Mind Out training to raise awareness among professionals of mental health issues and see this as a positive development. Young people are routinely involved in the recruitment of key health personnel and are well supported in this. Their views are given weight within the process and they have a real impact on the decision making process.

10 Parents and young people engaged with the learning disability service designed leaflets and letters for use within the service and young people engaged with substance misuse services designed posters for use in schools which can be tailored to direct children to staff they might talk to within that school.

11 There is some choice about the gender of CAMHS worker a young person sees and the service operates outreach clinics in Yate and Thornbury easing transport difficulties for patients. Some young people are also seen at school or at home according to their preference. Young people and carers have identified a need for after school/after work clinics and this is being explored. A local authority funded Barnardos worker within the CAMHS team supports young people's participation in CAMHS service development. This has facilitated the use of young peoples' art work in therapy rooms and their review of CAMHS environmental issues based on the '*You're Welcome'* criteria. As a result, privacy for those accessing the service has been increased through the use of window pictures and transfers.

12 Young people have good access to specialist midwives for teenage pregnancy and substance misuse who provide extended post natal support of up to one month and three months respectively, liaising well with health visitors to facilitate a seamless case transfer. Ante-natal and parenting support groups for teenage parents have been reduced however, due to declining attendance at evening sessions. To promote safe handling and positive attachment for new fathers, a short DVD in a range of languages is shown prior to discharge of mother and baby and all midwives are trained to answer any resulting questions.

13 With the support of funding from '*Above and Beyond'*, a clinician at the Bristol Royal Hospital for Children is developing a free parental advice app through which parents will be able to access medical advice sheets on a range of topics relating to children's health. As a result parents will be better equipped to deal with a range of childhood ailments more effectively and better able to recognise conditions needing emergency treatment.

14 The Bridge sexual assault referral centre (SARC) aims to give young people the lead in how the service is delivered. Young people are asked to sign the consent forms as well as their parents to give them control of the process. GPs are notified of the attendance of under 16 year olds at the SARC as required, but further information is only disclosed with the young person's permission. There is scope to extend the age range to include younger, prepubescent children who currently receive services through a separate paediatric clinic and this is being considered. A DVD developed with the police to engage young males in group discussions about sexually aggressive behaviour is used in outreach to schools in Bristol and is due to be extended to South Gloucestershire shortly. School nurses have not yet been engaged with this programme although they are well positioned and could provide effective follow-up with the young people once they have participated in the discussion group.

Outcome 2 Consent

15 Parental consent documentation for health assessments and sharing the child's information was completed and signed in most case records seen for looked after children. However, older children are not routinely invited to sign their own consent although they are likely to be competent.

Outcome 4 Care and welfare of people who use services

16 The acute hospitals' access to CAMHS for mental health assessments for young people works well, with CAMHS registrars routinely attending emergency departments when requested. Most young people present at the children's hospital, particularly out of hours, where the CAMHS team is based. CAMHS provision within the youth offending team (YOT) is working well and delivering positive outcomes. Redesign of the core CAMH service is under consideration with consultation on the proposed new model about to commence. The new model will include a crisis intervention team from April 2013. Access to CAMHS services has improved from 14 months to 5-6 weeks waiting time since the introduction of a choice appointment system in 2008, although some young people told us they had to wait longer than this to access CAMHS. Referrals are reviewed daily by two practitioners and the young person is then invited to phone in for a choice appointment.

17 For young people needing inpatient mental health treatment, Tier 4 services are provided at Riverside on the old Blackberry Hill Hospital site (or Glenside campus) with 10 beds serving South Gloucestershire, Bristol and North Somerset. The facility is about to be redeveloped and improved from the current mainly dormitory provision to provide single room facilities for young people, including two special care rooms and additional secure outside space. Interim arrangements are being put into place to ensure no loss of service during the building phase. No under 18s have been placed into adult facilities in recent years and young people requiring this level of service rarely need to be placed away from the area other than for an identified need for specialist or additionally secure provision.

18 Performance in undertaking initial health assessments within the expected 28 days of young people becoming accommodated has historically been poor and remains a challenging area for the partnership. This expectation was not achieved for 70 children out of a cohort of 92 in 2011/12. Performance on review health assessments is better, with 83% completed within expected timescales against an England average of 84.3%. The looked after children health team recognise that children might be entering and leaving care without having a comprehensive health assessment and have taken action to deliver improvements.

19 Health assessments are of good quality, taking account of the character, personality and voice of the child though the resultant recommendations are insufficiently carried forward into planning. The designated doctor who undertakes assessments is a consultant paediatrician, diligent in seeking health information prior to the assessment from a range of professionals involved with the child. This includes general practitioner, health visitor or school nurse. The designated doctor liaises regularly with schools regarding the child's behaviour and mood; correspondence to general practitioners is also copied to social care. Whilst health needs are well identified, the health recommendations are not routinely developed into outcome focused plans, although in most cases seen, completion of the tasks identified would deliver positive health outcomes.

20 South Gloucestershire has a lower teenage conception rate compared to the England average and there has been a steady fall in the number of terminations of pregnancy in women under 18, from 89 in 2007 to 50 in 2011. In 2010/11, 1.1% of women giving birth were aged under 18 years, similar to the regional and national average. Teenage pregnancy data is not broken down to identify pregnant teenagers or young mothers and young fathers among the looked after population. Commissioners cannot be assured therefore that the needs of this cohort are being met effectively or this data used to inform future service development

21 Young people have good access to specialist midwives for teenage pregnancy, substance misuse and sexual health services leading to beneficial outcomes and are well supported by health visitors and school nurses. A range of sexual health clinics across the county are open to all ages with dedicated young peoples' drop-in clinics in targeted locations, Kingswood, Patchway and Yate. Sexual health services for young people are branded 'No Worries' and in a survey of young people 80% recognised the brand though relatively few visited the website. More than 75% knew where to get free condoms and free emergency contraception. Coverage for Chlamydia screening in South Gloucestershire was 11.2% for 15 to 24 year olds between April and September 2011, the third highest in the region. South Gloucestershire positivity was higher at 7.8% than the South West and the England averages, indicating appropriate targeting.

22 Substance misuse services are provided in a range of settings including a multi-service young peoples' hub in Kingswood, a specialist worker within the YOT and different levels of support based on an annual needs assessment. The service is delivering positive outcomes for young people, assessed through the use of treatment outcome profiles (TOPs) and goal based outcomes measurement determined by the young person. Support is offered from lower levels to an assertive outreach model for young people with complex needs. Planned discharges are higher than the national average. Training is provided to school staff offering group work and to build school staff confidence in identifying and working with lower levels of substance misuse. Regular best practice forums held with schools additionally support this work.

23 Performance against immunisation targets for the population of children as a whole in the county is very good and exceeds national targets. A higher percentage of children (93.5%) have received their first dose of immunisation by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower at 89% of children though this is higher than the England average.

24 South Gloucestershire demonstrates good commitment to the *Healthy Schools* programme. Ninety-nine percent of schools achieved national *Healthy School* status up to April 2011and 41% of schools undertook the South West *Healthy Schools Plus* pilot, an outcomes focused programme in respect of schools with the highest health inequalities, between 2008 and 2011. Performance data indicates a higher incidence of young people smoking than the England average and a cessation of smoking worker now operates within schools.

Outcome 6 Co-operating with others

25 The LSCB is increasing its depth of scrutiny and challenge to health providers. In January 2012, the LSCB began to receive reports from the substance misuse service on the numbers of parents receiving treatment. This reporting requirement has now been strengthened to include a discursive report on how these children are being supported. The LSCB and commissioners have identified areas for development in adult mental health services in relation to sufficiency of level 3 safeguarding training and attendance at specific training events.

26 Partnership working at an operational level between different health disciplines; school nurses, CAMHS and others, with social care is consistently described by front line health staff as positive. Co-location with social care and other health disciplines is facilitating increasingly joint work. Specialist health staff located within other services facilitate young people's access to services by raising mutual professional understanding. This leads to more cohesive working across interfaces, an example being the specialist mental health worker in the youth offending service. The multi-agency sexual abuse practitioners group which meets regularly is well regarded by attendees as a valuable forum to undertake peer review on challenging cases, gain support for other safeguarding leads and to discuss practice issues outside of formal child protection processes.

27 Partner agencies are working effectively together to promote safeguarding, for example The Bridge (SARC) pathway is well established and provides effective support for young people aged 14+. Its impact and the promotion of its work are enhanced by positive partnership working in a number of areas. In particular, effective marketing of the self referral process, facilitated by the SARC's young person's counsellor, has resulted in a significant increase in use of the service.

28 Staff are clear about referral thresholds for social care intervention, aware of the resolution of professional differences protocol and are confident in its use and effectiveness. Most health staff report they would first discuss concerns with their named safeguarding lead or the on-call paediatrician before making a referral.

29 Consultant paediatricians routinely participate in strategy discussions as they operate a 24/7 rota and are therefore always accessible to give expert clinical opinion to inform safeguarding decisions. Where health is involved in strategy meetings or discussions, this involvement is not always well recorded on health records. However, health visitors and school nurses, who may be working regularly with a child and have important knowledge and information about the family, are not routinely involved in strategy meetings and s47 enquiries. Health staff's attendance at child protection case conferences is prioritised across community services and is routine. Practitioners feel able to assert their professional opinion in case conferences, they are part of the decision making process and their contribution is valued.

30 The common assessment framework (CAF) is well established and health practitioners participate routinely, making referrals and acting as lead professional in the health visitor and school nurse service and children with disabilities service although there is scope to increase the undertaking of this role. Eighty percent of community midwives are CAF trained and the service is represented on the CAF steering group. All teenage pregnancies are subject to a pre-CAF co-ordinated by the specialist midwife.

31 Health visitors are developing their services within children's centres and their links with Sure Start. Additional vulnerabilities being identified within families is leading to the development of an enhanced health visitor role. Recording practice is being strengthened to focus on evaluation of observations in relation to the impact on the wellbeing of the child. A new supervision model is being introduced to build on the family needs assessment framework and focus on outcome delivery. Health visitors and school nurses are also piloting the early intervention measurement tool (change tracker).

32 The multi-agency referral and assessment conference (MARAC) and multi-agency public protection arrangements (MAPPA) are well established. Well coordinated partnership work encompassing health providers is undertaken to protect children and young people who are at risk of domestic abuse.

33 Processes to quality assure the healthcare provision for young people placed in foster care or in residential care out of area are being developed but are not yet robust. The looked after children nurse undertakes health reviews for children placed in close proximity so that there are few children who are not seen regularly by the looked after children health team. Children placed more remotely may not return to the local area for some years and are likely to have highly complex needs making effective quality assurance by the partnership an essential component of service. While there is some quality assurance checking by the looked after children nurse, commissioners acknowledge this is an area for development. Where there are young people placed out of county for whom local CAMHS or other specialist health provision may not be available, the PCT commissions private provision.

34 CAMHS has set up an internal specialist team to support children living away from their birth parents (CLAB). This provides positive support to fragile placements, including educational placements, resulting in good outcomes. Consultative support is also offered to foster carers and other professionals with a specialist post to support specialist placements renewed on an annual basis. A weekly specialist CAMHS clinic for looked after children is responsive to the expressed needs of the young people who attend.

35 Services for children with disabilities are operating an effective team around the child model in partnership with parents. Coordination of therapies and appointments for children with disabilities is improving to minimise trauma to young people. Positive engagement between the community service and the acute hospitals is facilitated by specialist learning disability nurses within the acute trusts. A specialist nurse for palliative care through the Lifetime service (Sirona) has recently been put in place to strengthen support to children with life limiting illnesses.

36 Transition arrangements from children's into adult services are being strengthened. Work is in hand through the transitions operational group to improve the CAMHS transition pathways which have been identified as needing development. Two PCT funded transition posts are in place. The transitions policy for mental health is being redrafted. A questionnaire to capture young peoples' experience of transition into adult mental health services is currently being returned and will inform future arrangements. Access to adult attention deficit hyperactivity disorder (ADHD) services located in Bristol has been reduced from 18 months to 8 weeks, a significant improvement in access to these services for young people needing to transition into adult services. In common with other areas nationally, commissioners are aware of gaps in service for young adults with autistic spectrum disorders or Asperger's syndrome.

<u>Outcome 7 Safeguarding</u>

37 The children's trust and LSCB both have the full engagement of NHS South Gloucestershire and health providers. Lessons learned are evidenced through the implementation of improvements to safeguarding arrangements identified as areas for development in previous inspections and a serious care review (SCR). The local authority held a conference in Feb 2012 to address learning from SCRs which was well attended by health agencies. Attendees at the conference felt it to be engaging and helpful in strengthening practice within their services. However, there is more to do to ensure consistency, that learning from SCRs is demonstrably fully embedded across the health visitor service and that there is robust evidence that all potential risk indicators are addressed for each household visited. Not all health visitor records identified, recorded and addressed full information about a mother's partner living in a household. The LSCB newsletter and practice notes are reported to be disseminated regularly but frontline health staff are not consistently familiar with this. Operationally, there is good evidence that prompt action is taken by clinicians to raise safeguarding referrals when they identify risks to children however, with a number of case examples cited.

38 The child death overview panel (CDOP) is operating effectively and demonstrating reflective practice. Its annual report positively addresses a wide range of issues including: commendable actions of first responders, co-ordinated end of life care with children with life limiting illnesses, effective use of video conferencing to facilitate participation of multi-professional expertise in panels, development of specific protocols on salt poisoning and emergency care/primary care communication. A number of areas for development are also set out in the report including: lack of provision for paediatric palliative care, the vital role of health visitors in health promotion, occasional failures of parents and professionals to recognise the severity of a child's illness and challenges in paediatric processes. The CDOP reports annually to the LSCB with the report distributed across services or used to inform briefings and training. However there are no current links with the Health & Wellbeing board. Arising from the CDOP annual report the acute hospitals developed a leaflet to help parents to recognise if their child's condition deteriorates. Reception staff are being trained and coached to listen closely to parents' assessment of their child's condition on registering the child at A&E. One GP practice identified a change in their procedures as a result of the CDOP review of a child death due to asthma. Frontline GPs receive the annual CDOP report but felt that a regular digest or summary of CDOP issues and themes would be useful to them.

39 Safeguarding standards are embedded in health provider contracts, strengthening accountability for effective safeguarding service delivery. The designated doctor and designated nurse provide appropriate supervision and support to named safeguarding leads within provider services whilst setting clear expectations and monitoring providers closely. There is routine reporting of health providers' safeguarding activity and performance to the LSCB. Named health professionals within provider services are accessible and seen as a valuable source of advice and guidance. Whereas most services report close engagement with the named safeguarding professionals in their service, community therapists are less well informed about the LSCB than other community health service staff and are less well engaged with the named nurses in their service.

40 General practitioners (GPs) increasing contribution to safeguarding is encouraging and each practice has a safeguarding lead. The named doctor for safeguarding children is providing effective leadership in collaboration with the designated leads, and has a key role in the new clinical commissioning group. This ensures a continuing high profile for safeguarding under the new health arrangements from 2013. The regular primary care safeguarding leads meeting is a useful forum for peer review and developmental discussions valued by attendees. Whilst safeguarding training has been provided to dentists, the LSCB and PCT has more to do to ensure dentists and other independent contractors are fully engaged with arrangements.

41 The provision of appropriate facilities for young people held under S136 of the Mental Health Act is underdeveloped. NHS South Gloucestershire are aware of this issue and discussions are taking place between relevant providers, commissioners and the police with a number of options under consideration. While numbers of children are small, the length of time held in custody can be considerable and has the potential for a significant negative impact.

42 Health input into pre-birth planning is effective. Midwives feel their concerns are listened to when they raise the likelihood of early delivery to prompt early pre-birth planning. A pre-birth concerns planning protocol for maternity and social care services is in place and its effectiveness is reviewed through case sampling and peer review. The 'resolution of professional difference' protocol has been used to resolve cases where referrals from midwifery have been assessed as not meeting child protection thresholds. Whereas midwives have an understanding of equality and diversity issues, including female genital mutilation, there is scope for them to gain further understanding of cultural attitudes towards birthing practice and disability as the population's diversity increases.

43 Effective arrangements are in place in the minor injury unit at Yate and paediatric emergency departments of Frenchay and Bristol Royal Hospital for Children to identify young people who may be at risk and to communicate these concerns to named safeguarding leads and to social care. Reception staff are confident in raising concerns and alerting clinicians to issues or potential risks they identify through observations or initial patient registration, or which have been flagged on the patient record system. There is more to do to ensure the new IT system at the children's hospital is properly configured to effectively support safeguarding arrangements and this work is being addressed by the named doctor. All presenting young people under 18 and cause for concern cards are reviewed and subject to effective clinical governance arrangements. Access to the social care emergency duty team (EDT) works well overall when A&E seek information on specific children for whom they have concerns. However for the MIU the EDT route to out of hours access to information on whether children are known to services works less well. Referrals made through EDT are routinely followed up the next working day by clinicians at the acute trusts.

44 Systems are in place to notify primary care about attendance of children at emergency departments. An audit of effectiveness reported to the LSCB in April 2012 indicated where systems may need to be strengthened. Auditing of these areas has been increased to ensure the system is fully effective and embedded, thereafter the whole system will be subject to annual audit. Effective and proactive communication about any issues relating to individual children moving between services, compensates for information systems which do not have an effective interface.

45 Safeguarding practice within adult services is improving overall. Clear commissioner expectations are set out within adult provider service contracts. Services have appropriate trigger questions within assessment documentation. Routine discussions on safeguarding take place in team meetings and individual staff supervision. Internal audits are routinely undertaken on case records in substance misuse services and outcomes reported to commissioners. Attention is being given across adult services to embed a *Think Family* approach in front line practice to ensure issues which may impact on the safety of children are fully identified and addressed. The LSCB has recently requested a report on the support being given to children whose parents are engaged with substance misuse services. A longstanding difficulty within adult mental health services provided by Avon & Wilshire Partnership Trust (AWP) in achieving the LSCB and PCT expectation for key front line staff to attain Level 3 safeguarding training is being addressed with an expectation that the organisation will be compliant by September 2012. There is also close on-going engagement with AWP by health commissioners, CQC and the Strategic Health Authority to address concerns about the management and delivery of effective safeguarding practice.

46 Services for young people who have been the victim of sexual assault are well established with separate but effective pathways operating for under and over 14s. The sexual assault referral centre (SARC), The Bridge, provides local access to forensic services for anyone aged over 14. The service is person centred and sensitively provided, and follow-up support is good. Forensic evidence gathered is saved for seven years so a young person can decide to pursue a prosecution at a later date. Independent sexual violence advisors (ISVA) operate from the SARC, with one specialising in under 18s. Young people can access the free counselling service even if they have not accessed the forensic provision. Younger, prepubescent children currently receive good quality, supportive services through a separate paediatric clinic at Southmead.

<u>Outcome 11 Safety, availability and suitability of equipment</u>

47 At the Bristol Royal Hospital for Children, the alteration of the A&E reception desk to provide additional security to staff following some violent incidents limits the ability of reception staff to observe adults' interactions with children and young people in the small busy waiting area. Further consideration by hospital managers is warranted as part of the planning for the imminent expansion to the department.

48 Although no play advisors are assigned to A&E at the Bristol Royal Hospital for Children, staff can access play advisors from the paediatric ward as necessary. There is provision of some distraction equipment for children and facilities will be improved through the expansion. Young people's experience of A&E is sought through the use of Fabian the Frog interactive facility and monthly surveys undertaken by the youth involvement worker.

49 The minor injuries unit (MIU) at Yate has a single waiting area for adults and children. The area is covered by cctv and observed every 15 minutes by a member of staff during the busy period between 10 – 2pm as the area is away from reception.

50 Frenchay Hospital has a separate children's waiting room directly observable from reception as well as being covered by CCTV. Toys and distraction equipment are provided through fundraising or school donations. A popular "Daisy Bus" examinations bed is provided to facilitate children's receptiveness to examination and treatment. Treatment rooms are decorated in a child friendly way. A high level of consideration has been put into the development and décor of a family/quiet room. Arrangements are sensitive to families experiencing the death of a child, with clay models, handprints or locks of hair being provided. The direction of Mecca is also indicated. The department has good space capacity to enable flexible use of treatment rooms and cubicles to meet the different needs of children or young people who may have mental health issues or a cognitive disability, while still enabling staff to observe them.

51 Health occupational therapists (OTs) undertake some assessments for equipment for children with disabilities on behalf of social care OTs. Families have timely access to a wide range of equipment through the joint service, and to items of specialist equipment specifically funded by the PCT when necessary, with children with deteriorating conditions being given priority. However, the jointly commissioned equipment service has to date been unable to finalise the children's element of its catalogue. Therefore, the process for professionals to order items of equipment is not as smooth as it might be, Discussions on how to resolve this are in progress between Mediquip, the equipment providers and commissioners.

52 A new colposcope is being provided to the The Bridge (SARC) by the Soroptomists women's charity.

Outcome 13 Staffing numbers

53 Since the merger of the area's two health visitor services last year, work is in train to amalgamate best practice from both services to ensure consistent standards of practice. Health visitors are on trajectory to achieve their 2015 staffing targets and are in a recruitment process for 2.6 WTE new posts targeted to areas of identified high need and a specialist post to better support the traveller community.

Outcome 14 Staffing support

54 Safeguarding training is appropriately prioritised by the LSCB and PCT to ensure staff are trained to levels commensurate with operational responsibilities and in most areas this is progressing well.

55 Safeguarding supervision, as set out in Working Together to Safeguard Children, 2010, is well established in health visitor, school nursing and maternity services but is at different stages of development elsewhere in the health community. Named nurses (NBT) regularly supervise safeguarding leads within services on an individual basis. Individual supervision is also well established for health visitors and school nurses. A new supervision model is being introduced to these services to build on the family needs assessment framework and focus on outcome delivery. Maternity services have regular multi-disciplinary meetings to review cases and team meetings have a safeguarding focus.

56 Whereas staff in all services can seek out supervision or advice and guidance on an ad hoc basis, this is not sufficient to fully support effective practice. In response to specific incidents in midwifery services, the acute trusts' A&E departments and MIUs, debriefing sessions are arranged for clinical and non clinical staff and can be facilitated by the named nurses or midwife. Monthly multi-disciplinary clinical governance meetings in both Frenchay and the children's hospital review specific cases, with feedback to individual staff; lessons from these reviews also inform practice development. Regular, planned forums to give all clinical and non clinical staff an opportunity for reflective practice and regular safeguarding supervision are not established for community therapists, speech and language therapists, occupational therapists, physiotherapists, the acute trusts' emergency departments or minor injury unit's staff.

57 The looked after children health team has delivered training to the Through Care team on processes and the emotional needs of looked after children and is doing the same for the North and subsequently the South area team. Foster carers have received training on children who self harm.

Outcome 16 Audit and monitoring

58 The LSCB is increasing its depth of scrutiny and challenge to health providers including quarterly reports from providers on a range of safeguarding and quality indicators. The LSCB and commissioners identified areas for development in adult mental health services in relation to level 3 safeguarding training and attendance at specific training events.

59 GPs information arrangements include codings on their IT system to flag young people who are on child protection plans but flagging has not been routine or consistent for looked after children. Confusion among some GPs about how to code looked after children is currently being addressed to support improvements in the identification of looked after children.

60 A key contributing factor to poor performance on timeliness of health assessments has been the poor system for notifications by social care. New notification protocols have been put in place since April 2012 and an additional dedicated looked after children clinic has been established. The two clinics now operating at opposite ends of the area are showing early signs of improvements in attendance. Regular meetings take place between the looked after children health team and social care business support team to monitor and audit performance. Progress is being reviewed regularly with the social care service manager and reported into the LSCB. The designated doctor and the looked after children nurse meet fortnightly and have put systems in place that will facilitate improved performance, enabling them to focus on other areas for development.

61 A fully developed, whole system approach across the health and social care partnership is not in place to ensure good quality, timely healthcare provision for all looked after children, including those placed out of area. There is no forum in which the independent reviewing officers (IROs) and the looked after children health team meet to address health and social care service provision jointly. Health recommendations from health assessments are sent to the IROs. However the looked after children health team are not notified of statutory reviews and there is no effective mechanism by which they can oversee how well health needs are being addressed. The annual IRO report makes minimal reference to health with no evaluation as to how effectively the health care needs of looked after children are being delivered or monitored. The designated doctor has also identified the need to develop the annual looked after children's health report to the corporate parenting board to make it fully robust.

62 Performance on universal health outcomes for looked after children is positive, with 95% of looked after children having up to date immunisations at June 2012 against an England average of 79%. Some 85% of looked after children have regular dental checks against an England average of 82%. Data on how many looked after children are pregnant or how many care leavers are parents is not collected centrally by health commissioners and there is no data on how many male looked after children or care leavers may be fathers. Commissioners cannot be confident therefore that the needs of this cohort are being met effectively or used to inform future service development.

63 The health and well-being of children in South Gloucestershire is generally better than the England average. The infant mortality rate is amongst the lowest in England while the child mortality rate is similar to the England average. Obesity rates in South Gloucestershire have fallen since 2006/7. Children in South Gloucestershire have lower than average levels of obesity with 8% of children in reception and 16% of children in Year 6 being classified as obese. The rate of young people under 18 admitted to hospital for a condition wholly related to alcohol, such as alcohol overdose stands at 34.4 per 1,000. This is considerably lower than the England average of 64.5. Hospital admissions due to substance misuse (age 15-24 years) are 44.6 per 1,000 compared to the England average of 62.8. The percentage of children who say they use drugs equals the national average. The percentage of children who say they have been drunk recently is slightly higher than the England average.

Outcome 21 Records

64 The quality of records about looked after children is inconsistent and remains an area for development. Health visitors and other community health staff attend statutory health reviews and contribute actively to these. However, key social care information, social care plans and statutory review notes are not shared with health visitors and school nurses who may be closely engaged with the young person, so information relating to the child's situation and circumstances is incomplete. While there were examples of good recording practice, these were few. Examples of incomplete record keeping were seen which included a school health record not up to date with the child's address and current circumstances. Additionally, a school nurse sent information that a young person is sexually active to the social worker but this information does not appear on the looked after children health record. Although the looked after children nurse can access these through the social care record system, this is not sufficient to ensure a comprehensive health record or to fully inform key health professionals working with the child. Some hand written records are also very difficult to read and not all are signed in a way that identifies the worker clearly, examples of this being seen in health visitor records.

65 Records do not evidence that older young people are given a choice about having a private discussion to review their health with the looked after children nurse separate from their foster carer. A lack of choice could inhibit open discussion about sexual health, smoking or drinking, for example. There were few chronologies setting out key life events.

66 Some health service documentation does not currently require the nationality or first language and religion of the young person to be recorded, therefore there is a risk of cultural and religious issues/attitudes and needs not being fully considered in the delivery of health care.

67 The named nurse for safeguarding has undertaken a thorough and comprehensive audit of the health records for the inspection case sample, evaluated these well and identified further actions to be taken to address deficits both on individual cases and to inform wider health service development. An example is that named nurses are to undertake an audit of how the new supervision model is being operated and recorded.

Recommendations

Immediately

- *the LSCB and NHS South Gloucestershire should ensure that all independent health practitioners are fully engaged in safeguarding arrangements (Ofsted August 2012)*

- *the council, NHS South Gloucestershire and North Bristol NHS Trust should ensure that the annual independent reviewing officers' report includes how effectively the health of looked after children is addressed in statutory reviews (Ofsted August 2012)*

Within 3 months (from report)

- *NHS South Gloucestershire, North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust should ensure that clinical and non-clinical staff in hospital based paediatric services and the minor injuries unit have access to regular, planned supervision and reflective practice opportunities as set out in Working Together To Safeguard Children, 2010. (Ofsted August 2012)*

- *NHS South Gloucestershire, North Bristol NHS Trust, including the Community Children's Health Partnership, and University Hospitals Bristol NHS Foundation Trust should ensure that nationality, first language and religion are fully documented so that cultural norms can inform the delivery of appropriate health care. (Ofsted August 2012)*

- *the council, NHS South Gloucestershire and North Bristol NHS Trust and Barnardos should ensure that looked after children and care leavers are fully engaged in the development and delivery of the Being Healthy agenda. (Ofsted August 2012)*

- *the council, NHS South Gloucestershire and North Bristol NHS Trust should ensure that the provision of healthcare to looked after children is subject to an effective whole system approach and quality assured performance management framework. (Ofsted August 2012)*

- NHS South Gloucestershire, North Bristol NHS Trust, including the Community Children's Health Partnership, and University Hospitals Bristol NHS Foundation Trust should ensure that the healthcare records for looked after children are comprehensive and subject to regular audit and quality assurance.

- NHS South Gloucestershire and University Hospitals Bristol Foundation NHS Trust should consider whether accident and emergency reception staff are able to sufficiently observe the waiting area while ensuring appropriate provision for staff safety.

Within six months (from report)

- NHS South Gloucestershire and the Council should ensure that the process for supply of items of equipment for children with disabilities is streamlined.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.