

## Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Barnsley Metropolitan Borough Council

<b>Date of Inspection</b>	<b>25<sup>th</sup> June 2012 – 6<sup>th</sup> July 2012</b>
<b>Date of final Report</b>	<b>10<sup>th</sup> August 2012</b>
<b>Commissioning PCT</b>	<b>NHS Barnsley</b>
<b>CQC Inspector name</b>	<b>Jacqueline Corbett</b>
<b>Provider Services Included:</b>	<b>South West Yorkshire Partnership Foundation Trust Barnsley Hospital NHS Foundation Trust</b>
<b>CQC Region</b>	<b>North (East)</b>
<b>CQC Regional Deputy Director</b>	<b>Malcolm Bower-Brown</b>

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](#) .

<b>Barnsley Metropolitan Borough Council</b>	
<b>Safeguarding Inspection Outcome</b>	<b>Aggregated inspection finding</b>
Overall effectiveness of the safeguarding services	Inadequate
Capacity for improvement	Adequate
The contribution of health agencies to keeping children and young people safe	Adequate
<b>Looked After children Inspection Outcome</b>	<b>Aggregated inspection finding</b>
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being Healthy	Inadequate

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.

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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:**

Health services for children and young people in Barnsley are commissioned by NHS Barnsley Primary Care Trust in partnership with Barnsley Metropolitan Borough Council (BMBC) using a pooled budget. Community health services transferred from NHS Barnsley PCT to South West Yorkshire Partnership Foundation Trust (SWYPFT) in May 2011 as part of the health services reconfiguration. However, most of these services including CAMHS, school nursing and paediatric therapies continue to be managed by BMBC through a long-standing Section 75 agreement. SWYPFT currently directly provide and manage health visiting services and adult mental health services, although there are plans being developed for them to assume lead responsibilities across all community health services. The acute hospital providing Accident and Emergency services for children is Barnsley Hospital NHS Foundation Trust (BHNFT), which also provides midwifery and maternity services

## General – leadership and management

1. NHS Barnsley PCT and Barnsley Metropolitan Borough Council (BMBC) have a good understanding of the health of the local population through a detailed Joint Strategic Needs Assessment, and quarterly performance management reports that track key outcome areas including health. These reports highlight that Barnsley's performance in national measures of health outcomes for children, young people and pregnant women is a complex mix with a few areas of improvement, but several areas where outcomes were persistently poorer than comparator groups, and some that were deteriorating. In the latest available validated data (2010-11), rates of low birth weight babies was stable and in line with comparator groups. However, rates of substance misuse, deliberate self-harm and tooth decay amongst young people was higher. Rates of teenage pregnancy, smoking in pregnancy, and breast feeding had been significantly above comparator groups for some time and were increasing, indicating poor and deteriorating performance in these areas.
2. Although a joint strategic commissioning strategy is only in draft form, health and social care partners report that a shared vision is described in strategic documents such as the Children and Young Person's Plan and associated Prospectus, with priorities identified regarding work to improve health outcomes. There are formal pooled budget arrangements between NHS Barnsley and BMBC to support joint commissioning of services, and the majority of universal health services are managed by BMBC through long-standing Section 75 agreements. This has the benefit of improving integration between health and social care practitioners who are integrated into locality teams, and community health delivery is focused on local well-being centres. There was evidence that targeted health initiatives have been developed and were having a positive impact in improving outcomes in some priority areas. For example, immunisations rates in Barnsley are excellent at 93% (100% for children in care), and much higher than comparator groups due to input from a dedicated immunisation team established in 2009. Rates of obesity in younger children were very good and had been sustained at a level above national comparators, and although rates of obesity amongst older children were higher than comparator groups, this was improving. In addition, joint strategic commissioning was beginning to focus on addressing underlying contributory factors such as child poverty and literacy rates. For example, a multi-systemic therapy service (MST) supports families in parenting skills and has been successful in diverting children from care as well as improving school attendance and lowering offending rates. A new Child Poverty needs assessment was being undertaken to inform a strategy, and a Troubled Families service was being developed in line with national policy. However, much work is needed to establish a clear strategic vision and implementation plan across Barnsley services, and to demonstrate an impact across the range of health outcome measures.

3. The development of Clinical Commissioning Groups (CCGs) in Barnsley has been slow although health commissioning leads have been working to ensure the positive engagement of GPs in order to meet key milestones within timescales for the future commissioning of health services in the area. This has led to very recent meetings to agree a plan for preparation for devolving key responsibilities for budgets by October 2012. Action is being taken across health and social care to ensure that there will continuity of service delivery after April 2013, and that appropriate contingency plans are in place. This will enable work to be done to develop commissioning priorities, and link the CCG into current strategic planning and commissioning processes. However, there is a recognition that current arrangements are new and much work remains to be done to mitigate future risks in joint commissioning including strengthening partnerships and securing optimal engagement of partners in future planning.
4. There are insufficient systems in place to promote good strategic needs assessment, planning and service delivery around the health of children and young people who are looked after by Barnsley. The Children and Young People's Plan 2009-12 does not specifically refer to looked after children other and does not address issues around service planning or monitoring for this group. There has not been any system for identifying or reporting on health outcomes for these young people, although there are plans to develop this following the introduction of SystmOne, the computerised data base used in health services. There have not been clear arrangements or reporting lines for quality assurance, performance management and operational oversight of the health of children in care within NHS Barnsley. Previous annual reporting has been included within the annual safeguarding report, and does not meet the standards set out in national statutory guidance, *Promoting the Health and Well-Being of Looked After Children*. Health partners are not part of the corporate parenting board, and this undermines the potential of the group to consider and respond to all of young people's support and care needs. A designated doctor for looked after children is in post, although the protected time for this post includes clinical work, which has taken priority over the strategic aspects of the role. The designated nurse for safeguarding has assumed a role in undertaking aspects of the designated nurse for looked after children, although this is not specified in their job description. NHS Barnsley have acknowledged that the structures around governance of the health of children looked after needs to be revised and strengthened.

5. Health partners are well engaged in the Local Safeguarding Children Board (LSCB) and its sub-groups, and membership is at an appropriate level of seniority to enable decisions to be made on behalf of their respective organisations. Recent changes, including the appointment of an independent chair, have helped improve attendance and governance in the LSCB and Board members are aware of the need to sharpen the focus of board on strategic oversight of safeguarding performance. Some improvements are in process such as the almost completed development of a dashboard of performance indicators, and an increasing expectation for agencies to report on compliance with standards but the impact of these changes are not yet clear.
6. The implementation of action plans arising from recent Serious Case Reviews (SCRs) in Barnsley is ensuring that arrangements for safeguarding children and young people across health service provision are becoming stronger and more consistent. More robust systems and protocols have been implemented to ensure that there is adequate information sharing and joint working across front-line health staff. This is supported by more rigorous audit of practice which is demonstrating increased compliance with standards, for example in ensuring that midwives and health visitors undertake and record assessments regarding the identification of risk of domestic violence. Delivery of improvements is being monitored through governance arrangements, commissioning and reporting through the SCR sub-committee of the Local Safeguarding Children Board.
7. However, the LSCB has not paid sufficient attention to core child protection business and in particular the quality of child protection conferences, child protection plans and compliance with protocols for joint investigations. The inspection found significant variation in child protection work and managerial oversight across social care teams, including examples of poor practice which has left some children and young people at risk. There was recognition across stakeholders that the board should develop a more rigorous quality assurance role. Inspectors confirmed this view and saw examples, for instance, where action plans from serious case reviews had been signed off without sufficient evidence that the actions had been completed. Once shortfalls identified by the inspection process were raised with the council, immediate and appropriate action was taken to ensure that the children and young people identified were re-assessed and appropriately protected.

## Outcome 1 Involving Users

8. There are processes for young people to be involved in the evaluation of health services, such as the “You’re Welcome” scheme, (a national scheme involving young people in rating their experiences of health services), and representatives from the Youth Council had recently been involved in evaluating Barnsley College health centre and the Family Nurse Partnership service. Young people trained to be ‘mystery shoppers’ are used to evaluate contraception and sexual health services, which also has a user feedback process which had led to service changes, for example, developing ‘drop off’ centres for testing kits. The paediatric in-patient unit undertake regular surveys of children and families using the service and provide posters outlining action taken as a result of their feedback, which is good practice. There were some examples of user questionnaires being used across primary and community health services, although this was patchy and even when in use, the results of user feedback were not robustly linked into service review and development. Health providers acknowledged that this needed to be more consistent and widely established.
9. The Youth Council has been established that has good representation from a range of young people including from diverse communities, as well as a Youth Parliament for young people with learning disabilities. These, in addition to the Parents and Carers Forum provide opportunities for the engagement of children, young people and their families in the evaluation and development of services. Some effective work by the Youth Council led to conferences on E-safety in 2010 with presentations by young people. However, engagement of users and parents is too variable and is not fully embedded. For example, the complaints leaflet for BMBC, which applies to the health services that they manage, has been recently revised but young people were not involved in this re-design which was a missed opportunity. It is intended for the new leaflet to provide information to a wide range of service users and it is not in a format that some children would find easy to read.



10. Barnsley's Children in Care council is known as the Care 4 Us group, and this forum is chaired by a care leaver with good representation from a range of children in care, including those in residential homes and unaccompanied asylum seekers. Members of the Care 4 Us group who spoke to inspectors were clear that they have a strong voice in the development of provision for children in care, and that their views are taken seriously and acted upon. Examples included their contribution to the development of the Pledge, which sets out what they can expect from the council, and another instance where an issue raised by young people led to the clarification of when and how foster carers can give consent for overnight stays by children and young people. Members of the group are also involved in a national project where they review provision in other local authorities and report on its quality. The Care4Us group is represented on the Youth Council and looked after children play an appropriate role in the recruitment of senior council staff.
11. The children's rights service offers a number of opportunities for young people who are in care to have their views expressed, such as through drop in facilities at residential units. Care leavers have exit interviews to gain their views on their care experiences. Events to celebrate children's achievements are held regularly and provide opportunities for elected members and corporate parents to meet with a children and young people and to congratulate them on their successes.
12. There is a good range of information appropriate for children and young people about their health, and young people that the inspectors met confirmed that they were given relevant information. Care leavers are provided with health information and a new leaflet is being developed that will provide them with a portable summary of their health history, for example on immunisations.



13. The diverse needs of children with a disability are robustly assessed and considered within the work of the children with a disability team. A specialist team, the Health Integration team, provides a health service to people from minority ethnic groups and asylum seekers including unaccompanied asylum seeking children. This ensures that they are offered an initial health assessment, provided with appropriate information and are signposted to health services. A specialist health visitor post was being recruited to, to work with unaccompanied asylum seeking children as well as the gypsy and traveller community, which is intended to improve their engagement with health services and ensure that their cultural needs are considered when receiving services. Interpreter services are used well to enable a young person to participate more meaningfully in their care planning, and health practitioners confirmed that they have good access to translation services as required. However, documentation used for health assessments of children looked after by Barnsley do not include fields for specific questions on culture, gender, sexual orientation, or religion, and initial health assessment forms did not include fields for language and ethnicity. This undermines the assessment process, and in health assessments seen by the inspector, these areas had not been addressed or reported upon.

#### Outcome 2 Consent

14. There are appropriate policies and procedures in place for staff to ensure that parental or carer consent for treatment is obtained prior to any treatment of children and young people. The Fraser competency of young people is fully assessed within all services but particularly within sexual health. Accident and Emergency staff routinely establish who has parental responsibility for the child and therefore who can consent to treatment.
15. Appropriate information sharing protocols have been established across health agencies and their partners, and there was evidence that consent to share information was sought as appropriate including in undertaking health assessments for children in care.

#### Outcome 4 Care and welfare of people who use services

16. Rates of infant and child mortality in Barnsley are similar to comparator groups, as is the proportion of low birth weight babies. This is positive in the context of overall poorer health outcomes relating to pregnancy and birth, for example rates of smoking and teen pregnancy. Where a child death occurs, there is a rigorous process for action including rapid response to unexpected deaths. Protocols have recently been revised and a local panel established to enable a more timely response to deaths, information gathering and initial review between CDOP meetings, which is good practice.
17. The Child Death Overview Panel (CDOP) produces an annual report which includes some analysis of causes of death and identifies modifiable factors. The leading risk factor for child deaths in Barnsley is smoking by one or both parents, which accounted for one in four of the 27 deaths analysed. The CDOP report has limited data analysis and does not provide an action plan, although there is a section setting out brief information on nationally recognised good practice interventions. However, targeted health initiatives are being implemented – for example, health staff including those working in sexual health, midwifery and health visiting services are trained to promote a Stop Smoking programme. This had yet to demonstrate an impact, as the rate of smoking in pregnancy was above comparators and continued to rise in 2011-12. Health practitioners identified social and cultural factors contributing to difficulty in changing behaviour and promoting health in the local area, that is, a widespread acceptance of smoking and resistance to stopping. As noted above, clearer strategic planning was needed to underpin Barnsley's approach to addressing poor health outcomes and the underlying contributory factors.
18. A new health initiative to promote health in mothers and young babies, the "Having a Baby" programme, provides focused multi-agency education and parenting support from early pregnancy to post-natal care. This programme has improved rates of normal delivery and breast-feeding within the pilot group to 87%, (compared to 67% and 61% respectively Barnsley averages), and registration with Children's Centre services to 100% (compared to the Barnsley average of 67%). This initiative has recently received national recognition and the steering group have been invited to present a workshop at a National Conference in July. Public Health funding has been secured to support a transition plan to develop this approach across other areas in Barnsley. Other action taken to improve persistently low rates of breast feeding in Barnsley includes a recently established breast feeding peer support post, and link workers who follow up on all mothers who initiate breast feeding in hospital to offer sustained support in the community, although these have yet to be evaluated.

19. There was evidence of some good planning and co-ordinated work to support young people who are pregnant and ensure the well-being of their baby, with the involvement of the specialist teen pregnancy midwife at Barnsley Hospital. A pre-CAF is undertaken on all pregnant under 18s who access care with the Barnsley maternity services. The specialist midwife for teen pregnancy had strong links with the Family Nurse Partnership (FNP) who support young women through pregnancy and up to the child's second birthday. This promotes good perinatal planning and handover of care. A psychologist within the FNP promotes a focus on parental bonding and early attachment theory, which is recognised to promote positive outcomes in parenting. This is being reviewed with a view to extending access to support from the psychologist to other midwives to widen this approach.
20. Community health delivery is focused on local well-being centres, where multi-agency health and social care teams can tailor service delivery to the needs of the local population, for example tackling obesity through the MEND (**M**ind, **E**xercise, **N**utrition and **D**o it) programme. Each well-being centre has a leadership group that reviews issues in area and determine priorities, although there is no system at present to evaluate the effectiveness of this approach and determine its advantages over a more consistent service delivery, or to identify good practice that could be extended across other areas.
21. The links between well-being centres and primary care are under-developed, for example, there are insufficiently clear links between health visitors and GP practices which undermines good communication, information sharing and joint work in risk assessment although work is being undertaken to address this. Formal links across between well-being centre practitioners and children's centres are in place in some local areas, such as regular meetings to identify families at risk, but this needs to be developed to ensure consistency across Barnsley and to be extended to include GPs.
22. The development of a health centre at Barnsley College is an excellent example of innovative multi-agency working which has increased access to health for young people including targeted education about healthier lifestyles. This has led to some improved outcomes such as increased participation in activities and healthier eating.

23. Children and young people have good access to paediatric therapy services, and effective work has been done to reduce waiting lists across occupational therapy and physiotherapy services. A comprehensive review and reconfiguration of speech and language therapy (SALT) services has led to significantly reduced waiting times, based on targeted and time-limited interventions. This was too recent to evaluate outcomes or levels of service satisfaction, and while there was evidence that the changes had been welcomed by some practitioners and schools, it was recognised that there was a need to ensure that referring agencies and parents were clear about the changed service, referral criteria and benefits.
24. The Children with Disabilities team is multi-agency and includes a learning disability nurse, a general nurse and a family support worker, promoting comprehensive care planning and intervention. The team works with all disabilities including autistic spectrum disorder, social and communication disorders, and behavioural problems such as sleep difficulties, anxiety and anger management, and provide parenting training and support programmes. The specialist inclusion service integrated educational psychology, SALT, occupational therapy, physiotherapy practitioners and the disabled children teams in 2011, and provides a wide-ranging service to work with children with disabilities to support them in mainstream schools and community settings. This includes targeted work to improve learning and cognition as well as communication and interaction, and focused work with children with sensory impairment. Access to short breaks for children with complex needs have been enhanced with a new residential unit, in addition to a complex needs nursing team which enables children who are technically dependent and their families to have individually tailored support for short breaks in residential placements, at home or in other community settings such as during activities or days out. The team was established two years ago to meet an assessed need in services, but demand has outstripped capacity and the service specification is being revised to focus on those with higher or more complex needs.
25. The community children's nursing team offer care and support for children and young people at home with nursing needs, in order to promote early discharge from hospital and decrease re-admission rates. While capacity in this team is good and sufficient to deliver an immediate service with no waiting list, the team only operates Monday – Friday from 9 am to 5 pm. Outside of these hours, parents have to access the hospital children's assessment unit which has the potential to be less efficient, convenient or cost-effective. However, as is the case with all of Barnsley's therapeutic paediatric services, there was no formal evaluation or quality assurance to assess their effectiveness or indicate user or parent satisfaction levels.

26. Healthy lifestyles are promoted well in schools by school nurses, including personal and sexual health education. A Healthy Settings team is jointly funded by Public Health and BMBC to tackle health inequalities across the borough through health promotion in schools, well-being centres and children's centres, although the service has not been evaluated. The service specification is being reviewed to develop outcome measures.
27. Children and young people have good access to contraception and sexual health services including testing, contraception and advice across a range of community settings, although there are no pharmacies who provide emergency contraception. An enhanced C-Card scheme provides young people with an "Are you OK?" card that they can use to show partners that they have had health tests such as for chlamydia with negative results, and they can check their partner's status, which is positive. Staff have good links to refer young people to genitourinary services and there is good access to termination services where required. However, rates of teenage pregnancy in Barnsley are high and are increasing. A new sexual health strategy had been produced in draft form following wide-spread local consultation, and positively this addresses the impact of literacy, deprivation and inspirational factors on sexual health and rates of teen pregnancy. A task group was due to be launched that included a range of stakeholders to promote a multi-agency approach to implementing the strategy across health, education, social care, and youth services.
28. Positive multi-agency work was also being done to implement a co-ordinated approach to sexual health and substance misuse, in recognition of the increased rate of sexual risk-taking linked to use of alcohol and drugs. A "Sex, Drugs and Alcohol" steering group has produced a toolkit for staff working with young people or their parents and carers. Joint work was being undertaken with the police to target underage and street drinking through the Barnsley Community Alcohol Partnership, which established "Pub Watch" schemes to reduce illegal sales of alcohol, and street teams to intervene with young people found with alcohol. This has been audited and demonstrated a reduction in unsocial behaviour and street drinking in the target areas.

29. Hospital emergency admissions rates for young people have significantly increased over the last four years. While respiratory disease is the most common causal factor, numbers of children killed or seriously injured in road traffic accidents are higher than comparator groups. Trends in accidental injury have been analysed by Barnsley's Public Health department, and an accident prevention strategy is being developed, although this has yet to make an impact. Rates of young people using alcohol or other substances, and those admitted to hospital due to substance misuse are also higher than comparator groups, as are rates of hospital admissions as a result of self-harm. Barnsley hospital has no formal policy for responding to young people presenting at the emergency department with either of these risk factors, leading individual staff to make a judgement on the best action, for example, admission to the hospital or referral to specialist services. There was no link between the hospital and local substance misuse services for young people, although consideration was being given to developing this. While staff were confident that they would identify appropriate action, this had the potential for inconsistency of response and there was no system to assess the quality of actual practice, which is a gap in the service.
30. Health practitioners who had experience of making referrals to CAMHS reported widely varying quality of response in terms of timeliness, acknowledgement of referral and information about outcomes. Changes to CAMHS over the last two years had led to improvements in accessibility, including delivery of a service for 16-18 year olds, establishing an out reach service and providing a telephone contact advice and response service. These were welcomed by other health agencies and there was widespread acknowledgement that these changes were an improvement, for example in clarifying a single point of contact and availability throughout the week. The recent transfer of CAMHS into SWYPFT had led to other service changes, a significant part of which was the establishment of an Improved Access to Psychological Therapies service. Staff drawn from the team were undergoing training for this at the time of the inspection, with plans for the service to be operational within a year. An overall reconfiguration of the service specification for CAMHS is at the final stage of consultation. This has led to a period of uncertainty for the team, but there was evidence of an increasingly clear and co-ordinated vision for the service, based around an outcome focused contract. However, due to factors including increasing referrals and a number of vacancies, waiting times for access to routine first appointments for CAMHS services had increased during 2012 to ten to fifteen weeks, which is slightly higher than national guidelines.



31. Arrangements for promoting the health and well-being of children in care were inadequate. There is no named doctor for children in care although a medical advisor role is incorporated within the job descriptions of two associate specialist community paediatricians, who undertake all initial health assessments. Thereafter, all review health assessments for children under five are undertaken by a team of four associate specialist community paediatricians. However, there was a lack of clarity in the responsibility for undertaking initial health assessments for unaccompanied asylum seeking children, and one example seen that was not undertaken by a medical advisor was inadequate. Annual review health assessments (RHAs) of children aged five to eighteen are co-ordinated by the Health Advisor for Looked After Children, including those undertaken by practitioners for children looked after by Barnsley who are placed in other areas. Over recent years, performance in undertaking health assessments and dental checks has deteriorated due to staff changes and lack of capacity – in 2010-11, performance was at 60% and 68% respectively, which is poor. Capacity was further stretched in 2011-12, when a reciprocal agreement across South Yorkshire and Humber was implemented. This meant that RHAs of children were undertaken in the borough in which they are placed. As Barnsley has more children looked after placed in the area than they place in other areas, this has increased demand on the local team. To address capacity issues, arrangements have been made for School Nurses to undertake some RHAs, and work is underway to change service specifications so that School Nurses and Health Visitors will undertake more RHAs and improve future capacity in this area.
32. The health advisor for looked after children is located in the Future Directions team which oversees the health and education of children in care aged five upwards, as well as providing support for care leavers. This arrangement has benefits including that the health needs of care leavers are well addressed. However, there were difficulties in maintaining good communication with other social care teams, for example in gaining consent and getting relevant information in advance of health assessments. Timely notifications of children being received into care, or being placed in another area were not being consistently made by social care teams to the looked after children health leads. This undermines the ability of the team to undertake assessments within timescales.
33. Care leavers who spoke to inspectors were very positive about the support and advice that they receive from the Future Directions leaving care team and shared examples about how they were helped to register with GP practices and dentists, including being accompanied to appointments if they wanted this support, which is good practice. They particularly value a duty worker being in place but, as one young person said, anyone at Future Directions 'will help you and spend time with you'. The health advisor also runs groups such as 'cook and eat' sessions.



34. Recent service developments were being established to improve the number of targeted health services for children looked after. Work has been done to develop a clear care pathway for children looked after to access CAMHS, to ensure that they have a 'fast track' into services including a new service to support their emotional and psychological well-being. However, it is too early to have evaluated the impact on outcomes for this cohort. Positively, several examples of good work undertaken by a range of practitioners involved with children in care were seen relating to helping them understand why they were in care and to help them deal with emotional issues around their situation.
35. In addition, the Family Nurse Partnership service is reviewing its service specification to include targeting children in care. There are no specific services across midwifery and maternity services for children in care, although referrals can be made to the teenage pregnancy midwife as appropriate. School nurses ensure that they focus on the needs of children in care in their schools, including holding specific drop-in sessions, and young people that we met confirmed that they appreciated this – one said, "The school nurse keeps an eye on us". Substance misuse services provide training and input to registered children's homes within Barnsley.

#### Outcome 6 Co-operating with others

36. The use of the common assessment framework (CAF) is well established across the partnership and provides early effective and coordinated support to children and families. Early help services are being developed by the council, such as through Family Support teams which provide high intensity support for up to 80 families a week. There is no waiting time for this service which ensures immediate support is provided. The newly established and innovative Families at Risk Panel is starting to bring multi agency focus to families and neighbourhoods although it is too early as yet to assess the impact of this service.
37. A multi-agency Stronger Families team is in the early stages of development, with a plan to be launched in July 2012. This team is intended to provide early intervention for families who would not meet the criteria for other services, with sign-posting and advice for professionals working with them. Discussions were underway at the time of the inspection regarding the input or links with health teams such as CAMHS and health visiting.

38. There is a range of services to support parenting, including a multi-systemic therapy team (MST). This jointly funded, multi-disciplinary team that can provide an intensive intervention service to children, young people and their families to enable children to remain at home safely and prevent placement breakdown. An audit of this service demonstrated that it was successful in improving school attendance and reducing offending rates among young people, as well as improving confidence in parenting skills and familial relationships. While there was not analysis of how many were diverted from care, only two young people were received into care during the period of the audit, which is a positive indicator.
39. A parenting team based in CAMHS provides intervention to support parenting, and a "Dinosaur School" provides an 18 week programme for families with children who have autistic spectrum disorder or Attention Deficit Hyperactivity Disorder (ADHD). There are good links between midwifery services and Children's Centres to provide a range of parenting courses and support, including 'Preparation for birth' classes and specialist sessions for teenage parents. Health professionals across teams provide advice, training and input to foster carers on health issues relating to children looked after.
40. Although there were few formal protocols for the transition of young people into adult services, arrangements worked well without significant difficulty in engaging adult services or ensuring a smooth transfer of care. Transition arrangements for children with disabilities are supported through a specialist team. The small number of young people involved means that they receive individualised and appropriate support. A transitions worker in Addaction works with vulnerable young people aged 17 to 21 years old with substance misuse problems, ensuring a smooth transition to adult services where necessary.
41. NHS Yorkshire and Humberside had identified that reciprocal agreements for health authorities to be notified when young people looked after are placed in a different area to the council responsible for them were not working effectively. Health practitioners confirmed that they did not always receive timely information about young people placed in Barnsley who were looked after by other authorities, which undermines good information sharing. An action plan was in place to address this.
42. Looked after children and young people who engage in criminal activity are identified effectively and a range of multi-agency support is used to address their behavior, including restorative justice if appropriate. The percentage of looked after children who were cautioned and convicted has been below similar councils and national figures for three consecutive years but the latest data for 2010/11 shows a sharp increase. Youth Offending Team managers have taken appropriate account of the small numbers of looked after children who affect this statistic in their analysis of the possible reasons for this increase.

43. Adult mental health trust services have a flagging system to identify where their service users have dependent children, and there are systems in place to ensure adequate child care contingency plans are in place for periods of readmission. Training has been done to raise awareness of the “Think Family” approach, and assessment tools are used to identify hidden harm and young carers. There are appropriate family spaces on acute wards for children and young people who are visiting relatives.

#### Outcome 7 Safeguarding

44. The contribution of health partners to safeguarding children and young people is adequate. The designated doctor and nurse for safeguarding have clear roles and responsibilities in taking a strategic lead on the clinical aspects of safeguarding in health. Compliance with targets set out in safeguarding audits (Section 11 audits) across providers is good, and action plans are monitored to ensure targets for improvement are complied with. The designated nurse has undertaken targeted work with the named safeguarding lead for GPs in auditing safeguarding arrangements across Barnsley GP practices. This has led to increased compliance with standards including alerting systems and training. Positively, a new protocol has been agreed whereby social workers will contact GPs in advance of safeguarding case conferences for a telephone discussion in addition to requesting a written report, which has led to improved communication as well as efficiency.
45. Sound contract monitoring arrangements are in place between commissioners and health providers, and effective action is taken where safeguarding concerns are identified. This is supported by good governance structures across the acute and community health provider trusts that ensure that the boards have sufficient oversight of their arrangements to safeguard children. Self-assessment audits of provider trusts (Section 11 audits) indicate high levels of compliance with safeguarding requirements, and these are monitored by the LSCB and commissioners to ensure targets for improvement are complied with.

46. SWYPFT has a safeguarding team which includes named leads for Barnsley services that were transferred to the organisation in 2011. Safeguarding name leads are in place and are continuing to provide training, advice and support to staff although there has by necessity been a period of alignment of policies and systems across the organisation. This has led to the development of new safeguarding policy and procedures which have just been approved by the Trust Executive and are about to be rolled out across the service. Work on aligning performance management systems is underway, and there are plans to review the structure of safeguarding arrangements across the Trust. There are clear structures within the Trust for the governance of safeguarding, including a programme of internal audits and annual reporting. Recent audits indicated good compliance with safeguarding standards; although there was recognition of the need to ensure that information cascade about learning from serious incidents is consistently robust across all areas of the Trust's service.
47. The named safeguarding doctor and nurses at Barnsley Hospital NHS Foundation Trust were active in promoting awareness of and compliance with safeguarding standards and procedures, with clear reporting through internal governance structures. A part-time named safeguarding midwife has recently been appointed which has strengthened capacity to focus on this key service area and ensure support to staff in promoting consistency of safeguarding practice.
48. Health agencies and GP practices across Barnsley are implementing new "Did Not Attend" policies so that safeguarding issues are identified if parents are not ensuring that their children are attending appointments, which is good practice. Funding has been secured for a post to be based in Barnsley hospital to oversee the implementation of this policy, review non-attendance trends and follow up work. There was high awareness of the issues around non-attendance and need to establish effective systems to track and respond to it across all agencies at the time of this inspection, which is commendable.

49. Staff at the Emergency department at Barnsley hospital demonstrated a good understanding of safeguarding issues and risk assessment in both adults and children using the service. The system to flag children and young people who were subject to child protection processes worked well, and there was also a system to identify frequent attendances at the unit, which is good practice. Attendances of all young people at the Emergency Department are notified to GPs. There are clear protocols for Emergency Dept staff to identify and report concerns, including notification of safeguarding concerns to social care, to the hospital safeguarding team and Health Visitor Liaison nurse. However, systems to quality assure practice and provide regular learning and feedback to staff were underdeveloped. There was low awareness amongst emergency department staff about learning points from recent SCRs, and named nurses were reviewing ways to ensure that safeguarding training and updates were delivered more effectively. There is a high turnover of medical staff on rotation, and high use of locum medical staff due to vacancies; changes in staffing increases the need for good quality assurance systems to ensure consistency in safeguarding practice.
50. Barnsley hospital has specialist midwives to work with teenagers, and with pregnant women who have substance misuse problems. Maternity care pathway planning for these women was robust and effective. However, pre-birth planning arrangements for the wider range of vulnerable women are not ensuring sufficiently early engagement of social workers in multi-agency meetings to enable pre-birth assessment, work on parenting skills or planning for care proceedings. Some concerns were also raised that arrangements for parenting assessments needed to be reviewed, to ensure that they are sufficiently flexible and person-centred to ensure an accurate assessment of mother and baby interaction. There is limited access to mother and baby provision for Barnsley parents; although there are two private sector mother and baby units in the borough, these are infrequently used by Barnsley due to funding constraints. There are some mother and baby fostering placements in neighbouring areas, although health practitioners' experience of these varied widely, and successful placements appeared to depend on the availability of support from specialist teams in Barnsley such as the FNP.

51. The experience of health professionals who were making contact with social care teams to raise concerns about children in need or about safeguarding concerns around children and young people was extremely variable. Teams who were co-located or who had developed good links with social care colleagues felt that processes and thresholds were clear and that the response was positive. Other health practitioners struggled to understand thresholds, experienced inconsistency in their application, and felt that the quality of feedback was poor. A recent audit by Barnsley council had identified that there was disparity between perceptions across partner agencies of thresholds for making referrals to social care with the actual criteria for the service. Some training had been provided to health teams about thresholds, and a new referral process and system is being established. However, the findings of this inspection confirmed that there was significant inconsistency in the response of social care teams to notifications by partner agencies, and in deficiencies in subsequent action taken. Recommendations are made in this and in the joint Ofsted report, for the council and its partners to review processes and take action to address these concerns. Following a serious case review, health practitioners were now required to report third party concerns about child welfare – that is, when another person informed them about concerns. Social care teams would not act upon third party information and this discrepancy needed to be addressed to ensure good joint working.
52. Health practitioners were well represented at core group meetings and child protection conferences. Positively, a new protocol has been agreed whereby social workers will contact GPs in advance of safeguarding case conferences for a telephone discussion in addition to requesting a written report, which has led to improved communication as well as efficiency.
53. Multi-agency public protection arrangements (MAPPA) and the multi-agency risk assessment conference (MARAC) arrangements are well established, with appropriate protocols and representation from relevant agencies at suitable strategic and operational levels. Partner agencies work well together to identify and support children and families where there is domestic abuse. In most cases police appropriately risk assess families when they attend incident involving domestic abuse and promptly inform partners to enable assessment or support to be provided. Training is provided to staff across the partnership to raise awareness of domestic abuse. The local domestic violence strategy is being revised and is currently in draft stage.

54. Effective protocols, systems and practices are established to identify and support young people that go missing from home and those missing from education. Partners network well through the Young Runaways Action Group and children who go missing are supported well through Safe at Last, a local voluntary sector organisation commissioned to provide support. A sexual exploitation forum was established in 2011. Although this has not been evaluated, five strategy meetings have been held from thirty-five referrals, which is a positive indicator that it is promoting access to safeguarding processes for young people. This forum has now been combined with the Young Runaways Action Group with the intention that this will promote information sharing and risk assessment. There was no formal system to identify numbers of children looked after or address specific issues relating to them in this group, although children in care tend to be particularly vulnerable to exploitation.
55. Agencies across health, the youth service and education work collaboratively to prevent bullying amongst children and young people, and a multi-agency group is developing an audit of practice across the area. The group have developed an anti bullying strategy 2012 which includes bullying thresholds.

#### Outcome 11 Safety, availability and suitability of equipment

56. The physical environment of the paediatric emergency department at Barnsley Hospital is well suited to meet the needs of children and young people. There is sufficient space to promote privacy and dignity, including a dedicated waiting area for teenagers. There are appropriate toilet and hygiene facilities, and examination areas are decorated to a high standard in a style suitable for young people.
57. Although there is no dedicated resuscitation area, one space has been supplied with appropriate equipment for children and young people and this is adequate to meet their needs. Access to the resuscitation area for young people arriving by ambulance is via a dedicated entrance, but any young person needing to be moved from the paediatric area would have to be taken through the adult emergency department which is not ideal. It was reported that consideration was being given to extending the resuscitation suite which will provide an opportunity to review and improve this arrangement.



58. The hospital has a dedicated suite for the examination of children and young people who have been sexually assaulted, including providing forensic examination. The provision of this service across South Yorkshire is being reviewed. A consultation process was underway although consensus about the future delivery of the service had not been achieved. The chairs of the LSCBs across South Yorkshire had recently become involved in reviewing the situation with action planned to ensure that there were robust arrangements in place when the budget for providing Sexual Offence Examination services transfers to health commissioners in 2013.

#### Outcome 12 Staffing recruitment

59. Processes within the council and its partners to ensure safe recruitment of staff are effective overall and meet statutory minimum requirements. An appropriate range of checks are undertaken of the suitability of persons who have contact with children, including checks with the Criminal Records Bureau and these are regularly updated.

#### Outcome 13 Staffing numbers

60. There is a clear implementation plan for the FNP and health visiting service to ensure sufficient staffing to meet future needs. Capacity across midwifery, health visiting and school nurse teams is generally good, although work is being done to reconfigure the school nurse specification to focus on priority health areas.
61. However, the FNP care currently reviewing the service as capacity is stretched, and referral criteria will be more focused on vulnerable young women including children looked after.

#### Outcome 14 Staffing support

62. Both SWYPFT and Barnsley hospital services have given priority to providing safeguarding training to staff across the range of health services, including promotion of the "Think Family" approach in their adult services. Compliance with safeguarding training at level 1 and 2 was high across both agencies. Although 80% compliance with level 3 was not being achieved across the agencies, both were actively addressing this and working to ensure that data collection could accurately reflect take-up levels.

63. Named nurses in both agencies provide supervision to staff; health visitors and school nurses have regular 1:1 sessions. An early priority for the new named midwife role is to establish a robust system for supervision and support to midwifery and maternity services. Other staff confirmed that they have regular contact with named nurses including advice on cases, and access formal supervision on demand.

#### Outcome 16 Audit and monitoring

64. Performance Management is acknowledged by the local authority and its partners as an area which requires improvement and this inspection has confirmed that view. Performance and management information is collected by BMBC including for the health teams that it manages, but the analysis of the data is underdeveloped. As a result managers are not consistently able to use data to accurately identify the story behind the data, to analyse trends and the reasons behind any improvements or deterioration in performance. Performance in a number of key outcome areas is below that of comparators and has been so for some time, for example the undertaking of health assessments for children in care. Suitable plans are in place to address these areas of low performance, but despite the length of time that poorer outcomes have been known, progress in improving them has been too slow.
65. There is no clear system for the operational and performance management of practitioners undertaking health assessments for children in care, for quality assurance of assessment reports and action plans, or for identifying themes and trends arising from them. It is intended that the implementation of new arrangements for undertaking RHAs will enable the role of the health advisor to be developed into the named nurse for looked after children, with the operational oversight as set out in statutory guidance, which will be a timely and necessary development for the service.

#### Outcome 20 Notification of other incidents

66. There are satisfactory arrangements in place across the PCT, acute and mental health trusts to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC.

## Outcome 21 Records

67. A recent multi-agency case file audit undertaken in Barnsley identified that in a small sample of cases, reviews of looked after children were not seen on health visiting records although social care recorded that they had been sent. In the case files seen during this inspection, health assessments were not seen on all the health records provided. There were also different electronic systems available to health visitors, health teams managed by BMBC such as school nurses, and primary care health staff such as midwives and GPs. The lack of clear information sharing systems for the health of looked after children had the potential to undermine good communication and joint working.

## Recommendations

### Within three months

*NHS Barnsley PCT and its partners to review strategic and operational links with primary care health providers, with specific regard to the engagement of primary health in the delivery of services through well-being centres, and strengthening links with health visitors to improve risk assessment, early intervention and prevention (Ofsted, 2012)*

*Barnsley Hospital NHS Foundation Trust to review the arrangements in the emergency department for responding to children and young people presenting with deliberate self harm or who are intoxicated, and develop appropriate systems with robust monitoring and quality assurance systems. Barnsley Hospital NHS Foundation Trust to review arrangements for quality assurance of safeguarding training and practice across adult and paediatric emergency departments, and take appropriate action to strengthen systems (Ofsted, 2012)*

### Within six months

*NHS Barnsley PCT to take action to ensure that appropriate arrangements are in place to meet the health needs of looked after children in compliance with the statutory guidance "Promoting Health and Well Being for Looked After Children"; to include review of the capacity and role of the designated and named professionals for looked after children, and the development of robust arrangements for ensuring the strategic oversight and performance management of the looked after children's health team (Ofsted, 2012)*

NHS Barnsley PCT and its partners to review and align policies on response to third party information relating to safeguarding children and young people.

## **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](mailto:childrens-services-inspection@cqc.org.uk) and it will be followed up through the regional team.