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

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

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Provider services included:	Royal Berkshire Foundation Trust Hospital Berkshire Healthcare Foundation Trust
CCGs included:	South Reading North & West Reading
NHS England area:	South of England
CQC region:	South Central
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Contents

Summary of the review

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

Where the findings relate to children and families in local authority areas other than Reading, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

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

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

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

In total, we took into account the experiences of 47 children and young people.

Context of the review

Reading is an economically and culturally vibrant large town in central Berkshire. Significant population changes have been experienced in the last 10 years, with increasing numbers of new entrants and a relatively young population overall – nearly a quarter of Reading's population is under the age of twenty and 46% of school children in Reading are from a black or minority ethnic group.

The health and well-being of children on the whole in Reading is generally in line with or better than averages in other areas in England. There are fewer attendances at the Emergency Department for children under four years of age. Mortality rates for both infants and children, the rate of hospital admissions due to injury and as a result of self-harm, and the teenage conception rate in Reading are broadly in line with other areas.

The rate of children looked after as at March 2012, per 10,000 children under 18, was significantly more than the England average. Most of these are placed within 20 miles of where they used to live and Reading uses an above average number of family based foster placements, which helps young people maintain links with the area and the people that they knew prior to becoming looked after. The percentage of children in care with up to date immunisations in Reading was significantly better than that observed around the country, and 100% of children looked after had had their teeth checked by a dentist. However, data on the 2013 strengths and difficulties questionnaire data that is used to assess the emotional and behavioural health of looked after children within Reading indicated that there may be a high level of emotional difficulties experienced by children who are looked after in the area.

Commissioning and planning of most health services for children are carried out by the four Berkshire West CCGs including South Reading and North & West Reading, supported by the Central Southern Commissioning Support Unit. This is co-ordinated and overseen by Berkshire West Children Commissioning Strategy Group comprised of the four CCGs and chaired by a single Director of Joint Commissioning.

Acute hospital services are provided by Royal Berkshire Foundation Trust Hospital (RBH), including maternity and emergency services. The trust has a children's clinic which provides general paediatric clinics and specialist clinics located at Royal Berkshire Hospital with further clinics held within other local authorities. A paediatric assessment unit provides an outpatient service for same day GP referrals. The trust also provides a children's community nursing team including paediatric audiology and speech and language therapy services. Sexual health services are commissioned by public health and provided by RBH.

Community based services are provided by Berkshire Healthcare Foundation Trust (BHFT), including child and adolescent mental health services (CAMHS). The Trust also provides the looked after children's health team responsible for organising health assessments. There are a number of services commissioned by different agencies that are provided by the Trust - school nursing services are commissioned by Public Health (now with Reading Borough Council); health visitor services and the Family Nurse Partnership service are commissioned by the Thames Valley Area Team division of NHS England; and adult mental health services are commissioned by Berkshire West CCGs, supported by the Central Southern Commissioning Support Unit and provided by BHFT. Tier 3 CAMHs are commissioned by the CCGs. Tier 4 mental health services are part of NHS England specialist commissioning services, who maintain a list of approved providers.

The Berkshire Adolescent Unit is commissioned by four Berkshire West CCGs and is provided by BFHT. The unit offers assessment, medical and therapeutic treatment for young people with a range of mental and emotional difficulties through day- and out-patient care, as well as having the facility for up to five days per week in-patient care.

Substance misuse services for young people are commissioned by local authorities and provided in Reading by Source and the local authority internal provider. Adult substance misuse services are commissioned by Reading Borough Council and are provided by independent providers - KCA substance misuse service.

There are thirty GP practices in the area; ten in the North & West Reading CCG area, and twenty in the South. 38 percent of Reading residents are registered with GP practices that are part of the NHS North & West Reading CCG. There are some Reading residents that are registered with GP's that are a part of other CCG's and residents of other local authority's registered with Reading's CCG's but these are much lower in number.

The last inspection of health services for Reading's children took place in February 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from -

- A young person who told us that the Family Nurse Partnership "*really did help…It is nice to have the support at your lowest time and say anything and everything*". They also told us that they could talk to the school nurse about anything, and that they felt "*able to have a choice and make my own decisions*". Different health professionals "*worked around me*" and made the young person feel supported.

- A young person who told us that they felt involved in their health assessment, had a choice of venue, and got copies of the assessment and health plan from the looked after children's nurse. They felt that they had been supported by and benefited from the input of CAMHS, and "*could see a massive change*" in their behaviour. They felt that they "*would be able to talk to them about anything*".

- A young person who told us that the service that they got from the Berkshire adolescent unit was "*helpful and allows you to network with similar people*", and "*I've got nothing bad to say about them*". But, "*if I had a magic wand, it would be for GPs*" as they had to wait for a long time for appointments.

- A foster carer told us that they had had to be persistent to get information on the young person's health history, and to get specialist support for them. When this happened, it had been very helpful to the young person. The foster carer gets copies of assessments and health plans and said that "*it's all been pretty good*".

We heard about

- Difficulties in getting CAMHS services, and increasing waiting lists that meant that young people are not getting assessment, support and treatment in a timely way. Young people value and benefit from CAMHS input when they do receive it.

- Effective liaison across multi-disciplinary and multi-agency working which promotes good outcomes for families and young people. This was reflected in the majority of the cases that we heard about during the review.

- Good access to early help that supports families and vulnerable mothers in particular.

- A few instances where important information had not been shared or had not been recorded, which could undermine good joint working between professionals

- Work that is being done to improve the quality of the service that is given to children and young people who are looked after by Reading, and how this is improving health assessments and access into health services for them.

- Health professionals in adult community mental health services identifying the needs of children and young people, which led to them arranging appropriate support for families.

- Good access for young people to sexual health and substance misuse services

- How young people had been asked for feedback on CAMHS and services for looked after children, and saw examples of their input into information leaflets and posters

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 The Royal Berkshire Hospital ensures that the paediatric emergency department has sufficient numbers of trained staff on duty each shift to comply with national guidance. This ensures that children and young people are assessed and treated by staff with the appropriate skills and experience to identify their needs. The Trust has recently taken action to strengthen arrangements at the emergency department in response to complaints from people using the service. This has included improving access to paediatric consultants for advice and clinical expertise and to reduce waiting times, and staff told us that they feel supported by these arrangements. Training has commenced for nurses who are not paediatric specialists but who may look look after children to increase their knowledge of best care practice. For example, staff have been reminded to ensure that they explain the reason for tests to children and their carers and how they will be done, before they are undertaken.

1.2 Young people aged over 16 who are admitted through the emergency department are placed on adult general wards when admission is necessary. Safeguarding nurses at the hospital visit general wards daily to monitor the well-being of these young people. While it may be appropriate to the young person's needs and choices to be on adult wards in some instances, this will not be the case for all and there is a lack of appropriate alternative options for them. The executive lead for safeguarding at RBH has closely monitored the increasing numbers of young people admitted to adult general wards over time and demonstrated a good understanding of the issues that this presents. It was reported that plans to develop more appropriate facilities for adolescents are under consideration and would make a positive improvement in the experience of and outcomes for adolescents accessing the hospital (recommendation 2.1).

1.3 GPs, health visitors and school nurses confirmed that they received notifications of attendance of young people at the emergency department, which helps them to maintain an overview of the young person's health history and follow up on any issues as necessary.

1.4 Health visitors are routinely informed of pregnancies as initial assessments completed by the midwife are shared with them. This ensures that that health visitors are well prepared with relevant information when carrying out visits during the ante natal period. There are plans to introduce the 'Solihull approach'(a model to help understand children's behaviour) along with the 'ages and stages' toolkit which will support health visitors in the earlier detection of children requiring support.

1.5 Midwives link effectively with the Family Nurse Partnership and Reading's teenage pregnancy team and work jointly to provide a network of support to young mothers and fathers. We saw examples of intensive work to promote good attachment and child development, and we heard positive feedback from young people about the support that they had had and how this had helped them.

A teenager who became pregnant was provided with counselling services and was given a lot of information and support from different health professionals working with her. She told us that she felt that the information was consistent and had helped her to feel that she had a choice and was able to make her own decisions. She felt that she could talk to the school nurse "about anything and everything", and that workers "stood by her" and supported her. When she had the baby, she was helped by being offered flexible appointments, intensive support from the Family Nurse Partnership and attended mother and baby groups for young people. Help with school work and family work has helped her to return to school.

1.6 Midwives are able to make referrals to a team of locality based midwives known as the Poppy team, who provide enhanced support to women with a range of support needs, including mental health problems, substance misuse or learning disabilities. This team is supported by specialist midwife posts for domestic violence and for substance misuse, who provide training, advice and expertise so that expectant mothers receive effective support. The Trust is also in the process of identifying a designated person accountable for promoting awareness of forced marriage, and a Trust wide policy on the issue is currently in draft.

1.7 The Poppy team midwives link effectively with the peri-natal mental health lead based in adult mental health (AMH) who also provides training and advice. A peri-natal mental health pathway has been established that ensures that sufficient priority is given to this cohort of vulnerable women who would not otherwise meet thresholds for adult mental health services. This is a positive development that has had an impact on improving health outcomes for women with mental health problems and their children. Monthly multi-disciplinary pregnancy meetings and meetings with social care professionals are held at the hospital maternity unit to promote good information sharing and care planning for women and their children where there may be concerns.

1.8 Practitioners that we met in the adult community mental health team were able to demonstrate a good awareness of the needs of the wider family and contacts of people that they worked with, and made appropriate referrals to early help services. We saw examples of assessments with a good focus on the welfare of the child, and full family history including parental responsibility. Care plans outline signs of relapse and supporting factors that can be shared with other professionals to help in their assessment of and work with families. In one case, there was clear documentation of actions to be taken if a family member who was only to have supervised contact with children returned.

1.9 The jointly funded Compass Opportunities team offer support to women with mental health problems who have children and find it difficult to access services for child care. The team run a range of groups and work to promote recovery. The 'circle of friends' course is a six week course for mothers allowing them to develop self-esteem, confidence for themselves and their children, and to access peer support. The team focuses on promoting positive outcomes for women, which in turn supports their parenting skills and better outcomes for the child.

1.10 Berkshire Healthcare Foundation Trust have recently recruited practitioners with experience of working with children and families who will develop a role as 'champions' within both community mental health teams to promote awareness of the needs of children of people with mental health problems. We were impressed by the high standard of awareness and response to women and families in the practice that we saw at the community mental health team.

At an initial assessment by a midwife, an expectant mother disclosed a history of previous mental health problems. She also told the midwife that there was a period when her children were taken into care in the past. In line with Reading's Peri-natal Mental Health policy, the midwife made a referral to the Poppy team and to the adult community mental health team (CMHT) as well as to the children's social care team. The care co-coordinator at the multi-disciplinary CMHT made referrals to a range of health and social care and voluntary early help services. The mother was supported through her pregnancy and after the birth by a family support worker, HomeStart voluntary services, and attended a mother and baby group for women with mental health problems. Her family also had support, including at school and one child was referred to attend nursery. The care co-ordinator set up a Team Around the Child meeting, and the housing department were involved in helping to identify more appropriate accommodation. This provided a comprehensive network of support for the family.

1.11 We saw several examples of joint working including team around the child meetings attended by a wide range of health practitioners, and multi-agency working to support families. These consistently supported joint working and had led to positive change for the families concerned. However, in a number of cases that we saw, recording of minutes of meetings and action plans was not consistent, and in some cases details of contacts between professionals and information sharing was not recorded. This undermines effective joint working and increases the risk of key information being lost.

A Family Nurse Partnership (FNP) practitioner worked intensively with a sixteen year old young person, providing support from before the birth and more intensively afterwards. Support was also provided to the father of the child. Services were being provided by contraception and sexual health services and this was clearly documented. However, despite FNP practitioner engagement being clearly recorded, copies of care review meetings had not been uploaded and details of discussions held, who had been present at the reviews or what 'moving forward' plans had been decided upon were not recorded. If a different practitioner had to take on the case it might be difficult for them to see clearly what decisions had been made and the reasoning for those decisions at care review meetings.recommendation 3.1

1.12 Health practitioners regularly access services from across a wide range of early help options available to them, including multi systemic therapy (MST), family support workers, the Edge of Care team, HomeStart voluntary services, and 'Triple P' parenting programme to increase parenting skills. There are good links between midwifery, health visiting and school nurses with the Parents with Substance Misuse team in the drug and alcohol service. This means that they can refer parents to access a range of groups and support services to promote positive outcomes for both the parents and their children. We were told that there are good working relationships between health visitors and school nurses with other health agencies, including speech and language specialists and dieticians, and that referrals are promptly responded to.

1.13 Sexual health services are available and accessible to young people through clinics and outreach services with a range of opening times and which are focused on areas of highest need. Two specialist outreach worker posts have been effective in promoting access to CASH services for vulnerable young people and women, and providing them with additional information and emotional support in making choices. The LARC (long-acting reversible contraception) nurse works with the drug & Alcohol team on the Future Families project, an innovative scheme to provide support to women who have had children removed from their care which is about to be evaluated. Early evidence is that this has had a positive impact for the women that have taken part.

1.14 There is good access to termination services for children and young people although a recent reduction in service hours has had an impact on young people who require face to face counselling, effectively lengthening the process for them. The Marie Stopes service offers specialist counselling pre- and post-termination, and we heard from a young person who had really valued this service. However, practitioners identified that this service is not suitable for all young people and that there are insufficient suitable alternatives to meet their specific needs. This would benefit from further exploration to assess local need and service options (recommendation 6.2)

2. Children in need

2.1 Specialist children and young people's mental health services (CAMHS, also known as Tier 3 services) for children and young people across Reading are delivered by Berkshire Healthcare Foundation Trust. This is supported by "Tier 2" (less intensive support) services that are provided by Reading Borough Council's children's action team (CAT). The Trust's CAMHS was reorganised over the last two years to create a common point of entry (CPE). Other CAMHS services were restructured into clinical pathways in order to provide clearer and more focused responses to referrals. While some practitioners are very positive about the changes and experienced that the CPE had made access into CAMHS quicker, we heard from a number of health professionals who reported continuing difficulties in making referrals, and lack of clear pathways between CAMHS and the CAT which left some feeling that they were passed from one to the other with no resolution (recommendation 4.2).

2.2 In addition, since the reorganisation, referrals to the service have increased by 24%, with increasing levels of need identified. This has meant that the service is struggling to respond to rapidly rising demand, and is having to prioritise urgent cases means that those with lower level risk ultimately wait for longer periods for treatment. We heard from a range of health practitioners that they felt that waiting times to access treatment, and some specialist treatments in particular, is an increasing problem. We also heard that there are gaps in the provision of treatments for young people with autistic spectrum disorders, ADHD and personality disorders.

A GP referred a young person to CAMHS and was still awaiting confirmation that the young person would have an assessment some months later. The GP told us, "I am sure that if the young person was suicidal, that they would be seen sooner, but these waiting times are unacceptable".

2.3 Where young people up to the age of 16 years old present at the emergency department with deliberate self-harm, there is a clear pathway for them to be admitted to the paediatric unit and assessed the next working day by CAMHS. For those with other mental health problems, young people receive an assessment by a medical practitioner from Berkshire Healthcare Foundation Trust who has on-call access to a consultant from CAMHS. This consultant is available to attend the emergency department if necessary during working hours, and can provide telephone consultation out of hours. We heard that there are sometimes delays in young people getting timely assessments, and there are growing numbers of assessments needed out of hours for young people with increasingly complex or urgent needs. Capacity to respond is becoming stretched and arrangements are in need of review (recommendation 1.1).

2.4 The arrangements for young people aged 16 and 17 presenting at the emergency department with mental health problems are unclear and was identified as a source of concern by a range of health professionals that we spoke to. We were informed that a new service specification is being ratified and supported by increased resources to ensure that these assessments will be undertaken by the hospital liaison team from June 2014. This is a timely development but will need to be closely monitored to ensure that the team develop a sound skill set to respond to the needs of this vulnerable group (recommendation 1.1).

2.5 Once young people are able to access treatment from CAMHS, they receive effective treatment that is highly valued by them and their families. We heard from young people that they felt supported by CAMHS and saw examples of effective therapeutic intervention.

Child A was receiving support from CAMHS and this had helped them to understand the impact that their mental health problems had had on their health. They were more able to manage their behavioural problems effectively, and they felt supported by the service. They felt that they are well involved in their care planning by the CAMHS worker.

2.6 Reading has access to a facility at Berkshire Adolescent Unit that provides intensive mental health services on both a day patient and inpatient basis 5 days a week. This provides effective intervention for young people using the service, and is highly valued by practitioners as a resource. We also heard positive feedback from young people about their experience of treatment at the unit. However, lack of other appropriate facilities for young people with mental health problems, especially at "Tier 4" (intensive and specialist in-patient services), is resulting in long stays on the paediatric ward which risks impacting negatively on them as well as the care of other children. The problems are clearly understood by both providers and commissioners, and Tier 4 arrangements are under review by the commissioning body, NHS England. There is insufficient alternative provision locally such as assertive outreach or home treatment, and this has at times meant that practitioners struggle to provide an appropriate package of care, particularly when young people have urgent needs or are in a crisis and are at risk of needing an in-patient admission. While a review of CAMHS is underway, this is at the early stages of consultation with young people, their families and carers as well as practitioners. The outcomes and impact for service development are not yet clear and the situation for young people requiring high levels of support needs to be monitored to mitigate risk in the interim (recommendation 1.1).

A young person was attending Berkshire Adolescent Unit one day a week. They have 1:1 treatment as well as family therapy and group work. They told us that the meetings are "very helpful and allows you to network with similar people. I've got nothing bad to say about them".

2.7 There is a clear system for identifying and reporting on all young people who are placed on adult mental health wards. This had happened only once in the current year and was closely monitored by the Trust to ensure that the young person's needs were properly addressed while a suitable placement was found. Positively, Berkshire Healthcare Foundation Trust has developed two place of safety beds at Prospect Park which will be available for young people from May 2014.

2.8 Following a recommendation from the previous joint inspection, a formal transitions protocol has been developed across CAMHS and adult mental health services. This enables a handover and planning to begin six months prior to the young person's 18th birthday. However we found in one case that this had only taken place one month beforehand which left insufficient time for effective planning. The CPE is also co-located with adult mental health services which was reported to promote good information sharing particularly around transitions of young people although we did not see any cases to demonstrate this. We also heard that mental health representatives are attending a local multi-agency transitions panel which reviews young people aged 14-18 to promote planning for those who may not meet the criteria for adult mental health problems in order to identify alternative appropriate support for them, which is good practice.

2.9 Across health services that we visited, teams had effective systems for identifying cases of concern, including those that may not meet safeguarding thresholds, but might need extra support to ensure the well-being of children and young people. Maternity services used blue sheets in paper files to highlight these cases, and health visitors and school nurses have a 'pink folder', and meetings are held to discuss on-going contact and progress with them. Some GP practices are holding monthly meetings with health visitors to discuss cases where there are concerns and we were told that this is being encouraged as good practice across all GP services. This supports good information sharing and follow up when concerns are identified. The local Healthwatch told us that they had had feedback from young people and young carers that indicates that access to GP support around emotional and mental health problems is challenging for them and they would like to see this improved (recommendation 6.2).

2.10 The LSCB action plan for Reading details plans for embedding the use of the common assessment framework (CAF) through on-going meetings and training of key staff during 2013. Training in completion of CAF assessment forms is now part of Level 2 mandatory child protection training. The Poppy Team have attended local authority CAF training, and a rolling programme for community midwives to attend local authority training is underway. We saw examples of the use of CAF among health providers as a means of referring cases to children's social care; however some practitioners stated they require help in completion and did not think they are the most relevant person to be the lead (recommendation 3.2).

3. Child protection

3.1 Health professionals we met across the range of services that we visited demonstrated a clear understanding of child protection issues and routinely used risk assessment forms that informed decision making and prompted referrals as appropriate. They are clear about the role of and referral processes to the multi-agency safeguarding hub (MASH). The MASH process is operating effectively to ensure early notification of referrals across agencies, share information and secure appropriate action by relevant parties to promote early help as well as preventative work. We saw examples of referrals to the MASH from health professionals, but we did hear of some concerns from a variety of health professionals across a range of disciplines that they did not receive timely feedback from the MASH. This seemed to relate to hearing progress reports to assure them about what action was being taken, which would help them in working with the young people or families in the interim. While they are active in making contact to find this out, some are unclear about what they could or should expect in terms of communication. This would benefit from further exploration to gain a clearer picture of what the issues are and how it can be addressed (recommendation 6.1).

3.2 There is a clear system for 'flagging' young people who are on a child protection plan at the emergency department at RBH, and this will be extended to include identification of children looked after from 1st April this year. In addition, the child's previous attendances are highlighted so that staff can be aware of patterns of presentation which may indicate concern.

3.3 Staff in the emergency department are vigilant in following the hospital's procedure of providing a copy of their initial assessment in a folder for referral to the safeguarding nurse where children are under the age of one or where concerns are identified by staff. This process would benefit from review to ensure that there is clearer recording of when such referrals have been made so that there is a system to ensure that they are being tracked and responded to. Safeguarding leads monitor outcomes for children referred to them, we were not shown evidence of quality assurance to ensure that all relevant issues are being routinely identified and referred to them (recommendation 5.1)

3.4 GPs practices that we visited had good systems for flagging children and young people with child protection plans, although it could not be ascertained how they assure themselves that this is appropriately updated, and there is no consensus across practices about when GPs remove flags. In one practice, arrangements were made to ensure early registration of children temporarily placed in the area due to child protection issues, which is good practice and enables the GP to obtain a full health history at the earliest opportunity.

3.5 In the practices that we visited, we saw that GPs are also informed when children and young people are not brought to, or do not attend appointments. Staff are aware of the risks associated with this and the importance of contacting parents and carers to re-arrange appointments. Cases where non-attendance is a persistent issue are flagged and followed up. An electronic system to identify children who have missed appointments across the Royal Berkshire Trust has been introduced, and a process to utilise this information to support an annual audit is under development. The named nurse for safeguarding is copied into communication to allow for further enquiries if safeguarding concerns are identified by paediatric services where a child has missed an appointment which allows for further enquiries to be made as appropriate.

3.6 Effective arrangements are in place within midwifery teams to identify and record vulnerability in pregnancy. Standard risk assessment forms are completed at different stages of the pregnancy to document that appropriate enquiries are made about safety factors including domestic violence, mental health and FGM. We saw examples where this had effectively identified vulnerabilities and this had led to the midwife making appropriate referrals to the Poppy team and other support services. The lead midwife for domestic violence promotes good links with local forums for responding to concerns (multi-agency risk assessment conferences or MARAC), and ensures good communication about cases. Generally, health practitioners reported that they are alerted to instances of reported domestic violence, although in one case we saw, there appeared to be a lapse in notifying a midwife of two incidents that could have undermined her assessment of risk relating to a family that she was working with. Health practitioners across contraception, maternity, health visiting and school nursing are recording details of fathers and males in households which helps in the identification of risk factors, particularly where there is a history of previous concerns.

3.7 There are clear systems in the CASH service for the identification of risk for young people aged up to 16 (or 19 if known to the outreach worker). Identification of young people under thirteen years of age triggers a protocol including a safeguarding referral. Risk assessments include questions about family and domestic relationships and other professionals that would help identify if children's social care are involved or if the child is looked after. However, there is no process to flag young people who are on child protection plans or who are looked after, who would only be identified by a coding flag if they are being seen by the outreach worker. This could lead to missed information relevant to the risk assessment of the child (recommendation 5.2).

3.8 Child sexual exploitation forums have been established across each locality in Berkshire, and health professionals including CASH leads are well engaged in the development of these at both operational and strategic levels. The forum in Reading is in the process of fully establishing itself at an operational level and has yet to have an impact on identifying local trends and young people at risk, although stakeholders view the development positively.

3.9 Practitioners that we met in the adult community mental health team are able to demonstrate a good awareness of the Think Family agenda, and we saw some examples of good practice in identifying children and young people, assessing the impact of the adults' mental health problems and ensuring that appropriate support is in place for the whole family. Practitioners complete standard risk assessments at least annually, and the electronic form has recently been improved to ensure that when any risk is identified, this automatically links to create an action point on the associated care plan, which supports good practice. We saw examples of crisis care plans that contained details of relapse indicators and supportive interventions that are shared with other agencies to help them identify early signs of relapse and take appropriate action, which is also good practice.

3.10 Health professionals experience good working relationships with social care and positive engagement in joint work including pre-birth planning and support to vulnerable families around substance misuse and mental health problems. We saw examples of appropriate and timely referrals when risk had been identified, in consultation with safeguarding leads. Attendance at child protection conferences and core groups by health practitioners is good, although we heard that there are challenges in that there is insufficient notice of these meetings, which is a particular concern for GPs.

3.11 We saw some examples where health professionals had appropriately challenged decisions around risk assessment and action planning, and this generally is satisfactorily resolved at practitioner level without the need to use formal escalation processes.

A health visitor attended a review case conference for Child B, where it was debated whether the young person should remain as a 'Child In Need'. In the health visitor's view, the young person was demonstrating inappropriate behaviours towards peers and other professionals. The health visitor was particularly concerned about increasing problems at the young person's home. With this in mind, the health visitor documented her concerns in a report which she presented to the review meeting,. The result was a decision that the young person would remain 'at risk' pending further supportive interactions and that a further review would be planned. This ensured that the young person continued to receive support and their situation was monitored.

3.12 There are effective arrangements around child deaths, including a rapid response team which ensures that home visits are undertaken promptly and multi-agency meetings are convened within twenty-four hours, which is good practice. Support is provided to the family and staff involved, and there is good dissemination of learning from incidents.

4. Looked after children

4.1 Changes in commissioning have enabled the designated doctor for looked after children to undertake initial health assessments, where previously these were carried out by the young person's GP. This change supports greater consistency and improved quality of the assessment and subsequent health action plan. The designated doctor now holds clinics for assessments to be booked in, and this has helped drive an improvement in the timeliness of assessments. The availability of the designated doctor has been a particular benefit in improving access to initial health assessments for unaccompanied asylum seeking children, who previously had delays in accessing GP services when they did not have an NHS number. However, there are challenges in providing a timely service to all young people needing an initial health assessment, due to lack of capacity to be flexible in times and venues if the young person is unable to attend one of these clinics. There is no formal protocol in place but we were informed that in these infrequent circumstances, one of the specialist nurses undertakes a nurse-led assessment which is supported by a medical assessment arranged through the young person's GP. This process is not quality assured, and each case needs to be monitored to ensure that the young person is not disadvantaged by this arrangement (recommendation 4.1).

The designated doctor's initial health assessment of Child C, a new born baby was comprehensive and thorough. A full family history was recorded including details of the grandparents who are potential carers for the child, as there are concerns about the parent's ability to look after the baby. The assessment gave the reader a full understanding of the family background and the implications that may arise if the grandparents became the primary carers. The health plan was clearly linked to all the health issues identified in the assessment although it lacked specific timescales.

4.2 An increase in capacity in the health team for looked after children has enabled progress in the action plan to respond to recommendations made in the last joint Safeguarding and Looked After Children inspection, and to improve health outcomes for children looked after. Notable progress has been made in the timeliness of review health assessments. The specialist nurses in the team undertake the review health assessments for young people who are not in school and those needing an assessment at short notice. In addition, more child-focused documentation has been developed to improve the quality of health assessments, including greater consideration of ethnicity and cultural needs, linked to a more effective health plan. This is supported by links developed between health staff and Reading Borough council's cultural advisor for looked after children, who can provide advice and expertise to staff working with children and young people from different cultural backgrounds. We saw examples of good use of interpreters and sensitivity to cultural issues, for example the impact of being an unaccompanied asylum seeker on life choices, including pregnancy.

4.3 We saw a number of very good assessments and action plans by specialist nurses, giving the reader a full understanding of the family history and the health implications, and a real sense of the personality, character and voice of the child. Action has been taken within the team to ensure that this standard is consistently achieved. Review assessments for younger children and those in school within Reading are carried out by health visitors and school nurses. The looked after children's health team have lead a number of training sessions for these health professionals to enhance their understanding of how to undertake a comprehensive health assessment and use the new documentation. The sessions have included examples of Serious Case Reviews that have involved looked after children, and lessons learned from them. We were told that there are now systems for the specialist nurses to monitor the quality of review health assessments carried out by other professionals both within Reading and out of area. However, this is not a formal process and practitioners were unable to demonstrate how the quality assurance process is implemented. Examples were seen of action that had been taken when poor quality assessments or health plans were produced, particularly those undertaken by practitioners out of area. There is a potential for inconsistency in how the quality assurance process is applied, and young people's health needs may not be properly addressed without a more robust system (recommendation 4.1).

4.4 In further good practice GPs are routinely sent requests for information about looked-after children within their practice to ensure that initial health assessments are fully informed, although we were told that the response rate is very poor. Positively, there are good links between the specialist nurses and CAMHS, and a shared information system means that the specialist nurses and Health Visitors can access CAMHS reports instantaneously. However, school nurses do not have the same access to this information and there was no evidence that they are routinely requesting information to inform their review health assessments. A new prompt on health assessment forms ensures that trengths and difficulties questionnaires (SDQs) are requested, which would ensure that the young person's emotional well-being is taken into account. However, in all of the cases that we saw, these had not been available in time for the review and therefore are not being used to inform health assessment or planning. This is a missed opportunity not only to include key information but this could contribute to the new health passports to help young people map their emotional journey over time. Young people are routinely being asked about risk taking behaviours and substance misuse in their health assessments and reviews. Where young people are in contact with Source, Reading's substance misuse team for young people, regular and comprehensive assessments are undertaken to chart the person's progress across a range of health and social factors in addition to their drug use. There are good links between the looked after children's team and Source, although the opportunity to share this information, with the young person's consent, has not been considered. There would be benefit in reviewing the effectiveness of systems to gather and use the wide range of information relating to the health of children and young people that is available to practitioners undertaking review assessments recommendation 4.1).

4.5 The Berkshire-wide looked after children Strategy 2012-15 indicates that the mental health and emotional well-being of children looked after across the localities is given priority. This is a particular concern in Reading, where scores in SDQs have been consistently higher than the national average, indicating that there may be higher levels of emotional difficulties experienced by looked after children in the area. The strategy noted that a service user survey in 2012 indicated that young people are aware of advisory and counselling services relating to substance misuse and contraception, but would like health advice to be available from a range of universal settings such as GPs and youth workers as well as through targeted provision such as the specialist looked after nurses. This was identified as an area for improvement by some young people during this review (recommendation 6.2).

4.6 The looked after children's nurses provide training to foster carers on a range of health issues including meeting the emotional needs of young people in their care, and children looked after are given priority access to CAMHS which is good practice that ensures that their vulnerability is taken into account. Effective links between CAMHS and the specialist nurses for children looked after are supported by having an identified lead practitioner in CAMHS who oversees the pathway of young people into the service and also provides supervision to the nurses on case work. This would be strengthened by improvements in sharing information from SDQs not only on an individual basis but also by developing a process for monitoring trends across the area. This would help map progress against priority areas identified in the looked after children's strategy relating to removal of barriers to accessing services and ensuring that all looked after children are offered appropriate support.

4.7 Age-appropriate health information packs have been produced and health passports are now being provided to care leavers. In addition, drop in services for young people including those over sixteen and care leavers have been set up at locations that provide access to health and social care as well as the sexual health outreach worker. This promotes good health outcomes for this group.

5. Management

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

5.1 Leadership and management

5.1.1 North & West Reading CCG and South Reading CCG are members of the Berkshire West Children Commissioning Strategy Group, which is responsible for the co-ordination of children's commissioning across four CCG areas. The commissioning strategy group is chaired by the Director of Joint Commissioning and includes representation from all children commissioner stakeholders across Berkshire West, including the relevant CCGs, local authorities, public health and NHS England. Commissioning and planning of most health services for children is carried out by Central Southern Commissioning Support Unit on behalf of the four Berkshire West CCGs. Under the jointly agreed commissioning strategy, each CCG has an individualised commissioning plan that includes clear health outcome targets for children and young people, looked after children and safeguarding. Targets are informed by the local joint strategic needs assessment, NICE guidance and are linked to the health and well-being strategy priorities. The health and wellbeing board identified four goals which align with commissioning plans across Reading, and approved the commissioning plan summaries. One of these goals is to improve the focus on early years and the whole family, for example through promoting access to paediatric therapy services. These arrangements underpin a coherent vision and joint priorities for children's services in the area.

5.1.2 There is appropriate and active membership by health agencies at the local safeguarding children's board (LSCB) and its sub-groups. There is a single independent chair for all three LSCBs in Berkshire West, which promotes clear and consistent leadership. Appropriate frameworks for leadership are in place, and the multi-agency Board effectively drives good practice in safeguarding. For example, the Board commissioned a task and finish group to report on the safeguarding of children and young people with disabilities. The report of this work was presented in January 2014 and makes recommendations for disability champions to be appointed in each agency, and for the LSCB to promote specific training for safeguarding children with disabilities. Providers are to be required to develop strategies to demonstrate the inclusivity of children with complex and special needs.

5.1.3 The CCGs are well represented across the partnership with representation on the health and wellbeing board, child death overview panel and corporate parenting board. The child death overview panel meets bi-monthly and reported in 2012/13 that there had been a 55% reduction in peri- and neo-natal deaths across Berkshire, indicating effective delivery of preventative strategies, for example around co-sleeping. The CCGs work closely with NHS England, and have escalated concerns about relevant service provision relating to Tier 4 mental health services for young people. This is the subject of a review that is due to report imminently, which will inform the local review of CAMHS in the area.

5.1.4 There are clear reporting lines for the designated leads for children looked after to report to the corporate parenting board and LSCB, and there has been discussion at the CCG Safeguarding Committee, which reports into the Berkshire West Quality Committee of health services for children looked after, although this is not a regular item. The pan-Berkshire looked after children's strategy contains good analysis of needs with due reference to user views that were gained through a questionnaire. Feedback from these were used to set priorities and also helped identify which services children and young people already valued, which could be used to help build support networks for them. There was evidence of progress in action points in the strategy, e.g. increased resourcing of the looked after children's team and improved information sharing across agencies.

5.1.5 The CCGs have demonstrated good oversight of the capacity and functions of the designated lead roles in the area, and have taken action to address issues including increased investment in resources. This has been effective in strengthening the arrangements for the designated leads for children looked after. The designated nurse for looked after children has visited other areas to learn about good practice in the field, and is reporting to the CCGs with recommendations on how these lessons could inform local practice. However, the capacity of these designated leads remains stretched, and there is little capacity for them to provide a more strategic role which may help further develop the effectiveness of the team (recommendation 7.1).

5.1.6 There have been significant and long-standing gaps in the arrangements for leadership of safeguarding across the CCGs in Reading due to difficulties in recruiting to the designated doctor and named GP posts. Arrangements are now in place to secure input from a designated doctor across the whole of Berkshire, and community paediatric leads have been identified and are being trained to support her in the role to ensure adequate peer support, supervision and safeguarding cover in each Berkshire locality. Following an extended period where the named GP post for Reading was vacant due to difficulties in recruiting, arrangements have been made for the role and responsibilities to be covered through a combination of input from a named GP across all three Berkshire West localities, supported by a newly created post of named nurse for safeguarding primary care. This is a pragmatic response to the situation that has been agreed with NHS England, although it is too early to determine the impact. There will need to be continuing monitoring and evaluation of the capacity and effectiveness while these new arrangements are established (recommendation 7.1). The designated safeguarding nurse provides valued support and practice advice to health professionals across Berkshire West, although there has been an impact on the capacity of this post due to the continuing vacancies and changes in staff in Berkshire West and Reading in particular.

5.1.7 A strong commitment to involving and learning from the views of children and young people is evident in a growing number of areas of commissioning and service delivery, which is good practice. As noted earlier, user views were central to the development of the looked after children strategy, and a plan for consultation with a range of stakeholders in the imminent review of CAMHS services is well-developed. There were examples seen of user feedback and involvement becoming more embedded across Berkshire Healthcare Foundation Trust, including the development of health passports in the children looked after service, use of “How’s it going between us?” questionnaires by Family Nurse Partnership staff, and in the development of posters and leaflets for CAMHS, which are prominently displayed at sites that we visited. A number of participation events have helped young people and their carers to give feedback on what services they would value and these also identified people who wished to participate in further consultation events as the review of CAMHS progresses.

5.2 Governance

5.2.1 Appropriate frameworks are in place for governance and contract monitoring of services commissioned by the CCGs. The commissioning support unit and the LSCB regularly monitor performance in compliance with safeguarding training and progress on other recommendations from the previous safeguarding and looked after children report. The LSCB has introduced a more robust quality assurance framework to ensure that monitoring reports are presented regularly on key issues, and feedback is given to providers on key areas for development. While some progress has been made in the action plan developed from the inspection report, targets have still not been achieved and there continue to be areas of significant under-performance in compliance with safeguarding training and with supervision standards across different providers (recommendation 3.3). There is evidence of a more recent stronger approach to holding providers to account which is having a positive impact on service improvement, but this needs to be under-pinned by more robust challenge and evidence of improvement having the impact on health outcomes as intended. The LSCB's annual safeguarding report is presented to the health and wellbeing board who comment on progress in the action plan, providing an additional quality assurance check to local arrangements.

5.2.2 In 2012, the LSCB commissioned its quality assurance sub-group to undertake a practice audit relating to the quality of health assessments, and this was re-audited in September 2013. This is good practice that ensures that the board maintains a detailed and up-to-date overview of practice and continually updates action plans accordingly. The more recent review identified that significant progress had been made, although recommendations were made to ensure that there is robust collaborative working between the range of professionals involved in the care of looked after children.

5.2.3 A pattern of regular service audit is beginning to be established across the health community, and examples were provided of quality assurance that has included review of case work across Berkshire Healthcare Foundation Trust (BHFT), and a review of the quality of referrals made by health practitioners at the Royal Berkshire Hospital. These audits are comprehensive and provided evidence of active oversight of practice and outcomes. Both providers have robust governance and reporting arrangements to Trust boards and executive teams, who provide scrutiny of performance.

5.2.4 Across RBH there are acknowledged challenges in information systems that have undermined data quality when reporting on performance. Solutions to this are being actively sought. In addition, there are challenges for practitioners in using electronic systems to effectively support their practice. The use of paper-based records, particularly in services where these can be dispersed across different clinics or sites (e.g. CASH and midwifery) undermines good-record keeping, continuity and information sharing, as well as making quality audit more challenging. While case tracking during this review, we came across examples where information could not easily be located, information that had not been recorded and gaps in information sharing that could be addressed by having a more effective electronic system. The Trust leads are aware of this and, again, solutions are being actively sought. In the interim, close monitoring and quality assurance needs to be in place to address potential gaps in record keeping (recommendation 3.1).

5.2.5 Generally, we found that there was good evidence of multi-agency interaction that is being clearly documented, and some areas benefited from advances in information technology such as shared access to RIO and Framework-I (electronic recording systems) at the CMHT; information sharing between CAMHS and the looked after children's health team, and mobile equipment issued to health visitors and midwives. This investment in technology supports good practice by enhancing information retrieval, more prompt information sharing and better recording.

5.3 Training and supervision

5.3.1 Both RBH and Berkshire Healthcare FoundationTrust have well-resourced safeguarding teams that provide an effective screening system where practitioners have identified concerns or safeguarding issues, as well as providing guidance, training and support. Practitioners across the range of services that we visited are able to demonstrate a good awareness of issues relating to safeguarding, and teams routinely had meetings that included discussion of safeguarding issues, review of cases of concern and peer support. However, training across groups of professionals at Royal Berkshire Hospital Trust is not compliant with national guidance. This was the subject of a recommendation following the previous Safeguarding and Looked After Children inspection in 2012. Progress towards achieving the required level of training commensurate with role at level 3 in particular, has been slow, and this was reported to be linked to difficulties in accessing training as well as staff turnover. RBH has arranged bespoke multi-agency training in the current year, leading to an increased number of staff now at level 3. However, the target of 85% by the end of year is unlikely to be achieved; this means that key services including CASH, midwifery and the emergency department have been operating with less than 50% of staff who have had sufficient training in the identification, assessment and reporting of child protection issues. A clear focus needs to be maintained to ensure that training levels are achieved to underpin practice in safeguarding young people (recommendation 3.1).

5.3.2 Safeguarding training across Berkshire Healthcare Foundation Trust is reported to now be compliant with inter-collegiate guidance. Neither Trust has begun training relating to competencies in working with children looked after in line with revised inter-collegiate guidance.

5.3.3 Most health professionals across both provider trusts receive regular and structured safeguarding supervision in line with national standards, and we saw examples of this on records that had informed action planning for the case. We heard that ad-hoc advice, contact and supervision is readily available from safeguarding leads and was highly valued by staff. However, safeguarding supervision at CAMHS remains below national guidelines and local targets. While it was reported that group supervision is becoming established and increasingly effective at supporting good practice, this remains an area of concern (recommendation 3.1).

Recommendations

1. South Reading CCG, North and West Reading CCG, Berkshire Healthcare Foundation Trust and the Royal Berkshire Foundation Trust Hospital*:*

1.1 *are to ensure that there is are adequate monitoring arrangements in place to ensure that young people have timely access to mental health services to meet their needs during the period of review of CAMHS services in the area.*

2. South Reading CCG, North and West Reading CCG and the Royal Berkshire Foundation Trust Hospital:

2.1 *are to ensure that there is a clear plan to address the needs of all young people aged 16 to 18 years old who are admitted to the Royal Berkshire Foundation Trust Hospital that ensures that they have access to appropriate facilities on admission*

3. The Royal Berkshire Foundation Trust Hospital and Berkshire Healthcare Foundation Trust:

3.1 *are to ensure that quality assurance systems are in place to promote accurate and comprehensive record keeping across health teams*

3.2 *are to ensure that staff have training on the use of the CAF as appropriate to be confident in undertaking the role of the lead professional*

3.3 *are to ensure that staff have training and supervision relating to safeguarding and child protection in line with national guidelines and that there is a clear plan for compliance with training on children looked after*

4. Berkshire Healthcare Foundation Trust:

4.1 *are to ensure that robust quality assurance systems are in place to promote the quality of health assessments for looked after children and associated health action plans. This is to include review of the effectiveness of processes to request and use relevant health information as part of the health assessment.*

4.2 *are to ensure that there are effective pathways for referral to the Common Point of Entry for CAMHS that includes clear indications of when and how referrals will be directed to alternative services at Tier 2.*

5. The Royal Berkshire Foundation Trust Hospital:

5.1 *are to ensure that quality assurance systems are in place to determine the effectiveness of identification and referral of child well-being and protection issues across staff in the adult and paediatric emergency departments*

5.2 *are to ensure that information about young people who are on child protection plans and those who are looked after children is available to staff in the contraception and sexual health service and appropriately flagged on records*

6. South Reading CCG, North and West Reading CCG and its partners:

6.1 *to review the effectiveness of feedback and communication from the MASH to ensure that health professionals have timely and appropriate information to support them in working with families when they have made a referral*

6.2 *are to undertake further needs assessment relating to the experience of young people accessing advice, support and counselling through primary care and universal settings and develop an appropriate action plan to address identified service developments*

7. South Reading CCG and North and West Reading CCG:

7.1 *to review the effectiveness of the arrangements regarding the designated leads for safeguarding and for children looked after to ensure that there is sufficient capacity to undertake the requirements of the roles*

Next steps

An action plan addressing the recommendations above is required from North & West Reading CCG, and South Reading CCG within **20 working days** of receipt of this report.

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