

**Review of health services for
Children Looked After and
Safeguarding in
Bath and North East Somerset**

Children Looked After and Safeguarding

The role of health services in Bath and North East Somerset

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Provider services included:	Sirona Care & Health Royal United Hospital Bath NHS Trust Avon and Wiltshire Mental Health Partnership NHS Trust Oxford Health NHS Foundation Trust Developing Health and Independence Bath and North East Somerset Doctors Urgent Care Ltd (BDUC)
CCGs included:	Bath and North East Somerset Clinical Commissioning Group
NHS England area:	South West
CQC region:	South (West)
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Bath and North East Somerset. 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 Bath and North East Somerset, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

We tracked a number of individual 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 64 children and young people.

Context of the review

There are just over 36,000 children and young people aged 0-19 in Bath and North East Somerset's (BaNES) making up 23% of the total population of 176,000. Males account for a slightly higher proportion of the younger population than females. Children and young people make up 23% of BaNES's population with 10% of school age children being from a black or minority ethnic group.

On the whole, the health and well-being of children in BaNES is generally better than the England average. The infant mortality rate in BaNES is better than average and the child mortality rate is not significantly different to the England average. Teenage pregnancies, overall, are in line.

In the last 3 years BaNES's Drug and Alcohol Treatment services have gone from being one of the worst performing in the South West to being in the top third in 2012, and performance is still improving. Alcohol related hospital admissions in BaNES have risen on average 12% every year since 2002.

At 31 March 2014 there were 123 children subject to a child protection plan in BaNES. This equates to 36.1 children per 10,000 children.

Bath and North East Somerset has the highest number of services in the South West which have been accredited with the SAFE (Sexual Health Advice for Everyone) and You're Welcome standard for being young people friendly. This service is a free confidential sexual health service for young people, operating in various schools and youth clubs throughout BaNES. It is staffed by members of the school nursing service.

The teenage conception rate in BaNES is the lowest in the South West. It has reduced by 22% in BaNES since 1998. It may be rising again however.

Commissioning and planning of most health services for children are carried out by BaNES Clinical Commissioning Group (CCG) and BaNES Local Authority. The Senior Commissioning Manager is a joint post across the CCG and the local authority.

Commissioning arrangements for looked-after children's health are the responsibility of BaNES CCG and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by Sirona Care & Health.

Acute hospital services are provided by Royal United Hospital Bath NHS Trust (RUH) and Bristol Children's Hospital. From 1st June 2014 the RUH took over from Great Western Hospitals NHS Foundation Trust in running the maternity services provided at the following locations:

- Princess Anne Wing, Royal United Hospital*
- Trowbridge (Wiltshire)*
- Chippenham (Wiltshire)*
- Frome*
- Paulton*
- Shepton Mallet*

Wiltshire CCG remain the lead commissioner for maternity services, working in partnership with BaNES CCG.

Since April 2014, a new Urgent Care Centre (UCC) has operated at RUH, adjacent to the emergency department with a shared waiting area. This UCC is provided by Bath and North East Somerset Doctors Urgent Care Ltd (BDUC).

School nurse services are commissioned by BaNES Local Authority and provided by Sirona Care & Health.

Contraception and sexual health services (CASH) are commissioned by BaNES Local Authority and provided by Sirona Care & Health.

Child substance misuse services are commissioned by BaNES Local Authority and provided by Developing Health and Independence (DHI / Project 28).

Adult substance misuse services are commissioned by BaNES Local Authority and provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) (Specialist Drug and Alcohol Service SDAS) in partnership with Developing Health and Independence (DHI).

Child and Adolescent Mental Health Services (CAMHS) are provided by Oxford Health NHS Foundation Trust.

Adult mental health services are provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP).

The last inspection of health services for Bath and North East Somerset's children took place in January 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. At that time, health's contribution to children's safeguarding and the provision of health for looked-after children were both judged to be inadequate. 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 women using midwifery and maternity services;

“The midwives were really great. They maintained the plan of care and I was induced quietly and calmly. They updated me all the way through and it was much better than I anticipated”

“The midwives at Paulton were good. Problems were referred to RUH and I felt well supported”

Foster carers told us;

“Personally, I love working as a foster carer for BaNES. All services, CAMHS, nurses and the health visitor; all support has been brilliant. CAMHS are brilliant, appointments are quite quick. We’ve not had to wait long. They are adaptable. We’ve been seen in dinner breaks and after school”

“When a child has complex health needs and sees different consultants, hospital departments should talk to each other and see the child on same day if they are able to”

“We have no choice of venue when paediatricians do the looked-after child health assessment”

“Sometimes, I’ve not been informed fully of issues about the child such as sexualised behaviours. We only get partial information about a child’s history. Knowledge only helps you to understand and give the child the right support”

“Health visitors are easy to contact. They are very good and spent a lot of time with the children”

“The health visitor’s support is very useful and she keeps in touch. I found her advice in giving baby massage helpful”

“When a product that the child had been using regularly wasn’t available any more, the doctor went out of her way to find a substitute. I’d previously been informed there was not much they could do for the child’s eyesight. His new optician prescribed glasses and his eyesight is now improving. The orthodontist takes time and thinks of him. All treatment received has been more than I expected, I cannot fault anything”

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 Across all services, we saw and heard examples of good communication and liaison between frontline staff which support vulnerable children and families into early help support services. In many cases, this provision, which includes support from services such as children's centres, Project 28 and LIFT have resulted in improved parenting capacity and good outcomes for children. A positive local outcome from the additional resources for the health visitor service delivered through the national Call to Action programme, has been the development of a stronger early help offer. Health visitors have been able to initiate and support a range of early help services.
- 1.2 The "Moving On Up" group combines dance tuition with peer support for mothers with low mood. This was an initiative by a health visitor working with another professional. The provision of a crèche in a separate room enables mother and child to spend constructive time apart. This gives the mother respite from their caring responsibilities and enables the child to socialise with other children. Due to the positive outcomes in increased parenting capacity from the initial group, this provision has been expanded and women across BaNES can access groups in their area. We also heard about "Stepping Stones", a recently initiated peer support group for parents with mental health needs, jointly initiated by a service manager in Children's Social Care and a practitioner in Avon & Wiltshire Mental Health Partnership NHS Trust (AWP).
- 1.3 There are other innovative early help developments. These include school nurses working with individual young people with low level depression to develop an Emotional Health Diary. Another example is the development of easy read contraceptive information for young people with learning or literacy difficulties. This could be used across a range of services and the possibility of developing it into an application for use on electronic devices is being explored.

- 1.4 New mothers, currently engaged with the midwifery service, gave us positive feedback about their experiences. Midwives were all very positive about the recent transfer of the service to the RUH trust and improvements that have been made to the patient pathway. Midwives work well with other agencies and disciplines, ensuring that services are informed promptly about safeguarding concerns for unborn children. Risk assessment is not fully robust however. The assessment template does not prompt the midwife to ensure she has seen the mother-to-be on her own and to record who accompanied her. It is not routine practice to ensure this happens and is documented. As a result, the woman may not be able to communicate freely with the midwife about any issues of domestic violence, exploitation or other safeguarding concerns. Giving the woman this opportunity may be a critical factor in considering the possibility of sexual exploitation (CSE) and other safeguarding risks (**Recommendation 1.1**).
- 1.5 Transfers of cases from midwifery to the health visitor service are done well. When a baby has to remain in hospital, midwives keep health visitors up to date, ensuring that when the health visitor undertakes her initial visit, she is well informed about the baby's situation.
- 1.6 While there is no discrete peri-natal mental health service with a specialist psychiatric consultant, the joint clinic operated by Avon and Wiltshire Partnership Trust (AWP) Acute Hospital liaison team and specialist midwives is an effective short-term support. AWP also offers peri-natal support within the range of services provided by its mother and baby unit in Southmead, Bristol and no gap in service for BaNES has been identified.

Practice example 1: *A new group for parents with mental health problems has recently been established by an Avon and Wiltshire Partnership Trust practitioner in partnership with BaNES council. This group, Stepping Stones, provides parents with a good opportunity to gain peer support, build self-esteem and resilience and improve parenting capability.*

The group offers;

- *A parent and child club facilitating relationship development and communication in a safe environment*
- *One to one work as a family, if specific needs are identified*

Parents are helped to have improved insight into mental health difficulties and how these impact on their children.

Feedback from parents is positive;

"I have had a place to open up, face to face with support and not feel judged, which helps me so much it's indescribable"

- 1.7 LIFT, an increasing access to psychological therapies (IAPT) service operated by AWP and co-located with the primary care liaison service offers a stepped programme of psychological support to those to people with common emotional, communication and mental health difficulties; this includes support to parents where children may be made vulnerable to harm as a result of low level parental emotional health issues. Parents can self-refer to the service, which demonstrates good outcomes. AWP are planning to bring LIFT, the primary care liaison service and the intensive team into an arrangement with a single point of access. It is expected that this will facilitate the engagement of parents more promptly with the most appropriate level of support.
- 1.8 Health visitors' use of promotional guidance cards at antenatal visits is positive, ensuring that key issues are discussed in an interactive way which parents are likely to find helpful and engaging. Development of an initial needs and risk assessment for health visitors is in hand, to strengthen practitioners' written analyses and evaluations of risk. Currently, health visitors use creative strategies to see rooms in the parental home by exception if they have concerns that there may be environmental risk. There is an opportunity to include observation and evaluation of home environmental risk factors as routine practice by including these in the new documentation.
- 1.9 Health visitors work closely with other agencies, particularly midwifery, children's centres and children's social care to support vulnerable children and families. GPs are also meeting regularly with health visitors to discuss vulnerable families. GP practices we visited have effective flagging on their patient record systems enabling primary care staff to be aware of known vulnerabilities to children and their families although GP's are aware that they may not always hold up to date information regarding children and young people in their practice. In one case reviewed, although agencies had been involved with a mother with children subjected to domestic violence from her partner, the GP had been unaware of the situation and the resultant vulnerabilities of the children until the woman attended the surgery and disclosed the information.
- 1.10 Young people have easy access to good quality contraception and sexual health services. Clinic in a Box and the school nurse sexual health outreach services are working effectively; increasing engagement with schools, youth clubs and colleges to further facilitate young people access to these services. However, the risk assessment used by CASH is protracted and not easy for staff to use. It also does not capture the assessor's observations or details of the young person's demeanour which may be essential components of the evaluation of risk. A review of the proforma is being undertaken (**Recommendation to 2.1**).

- 1.11 Access to contraception services for young people has been expanded, offering good early help support which encompasses younger teenagers. Education and training has been provided by the lead doctor to pharmacies within the BaNES area on sexual health allowing them to offer services for children aged 13 plus. The pharmacies offer contraception, the morning after pill and Chlamydia screening services.
- 1.12 Where a young person accesses the service seeking termination of pregnancy, clinicians take into consideration the full family situation when advising the young person of the options available and the risks linked with each option. In the school nursing service, sexual health records management is inconsistent. Clinic in a Box notes may not always be married up with the main school nurse notes in a timely way. This may mean that the school nurse notes are not always up to date. As a result, information about a young person may not always be readily available to practitioners or managers in the school nurse service. CQC has also drawn these areas for development to the local authority's attention as the commissioner of the service (**Recommendation 2.2**).

Case example 2: *A young woman aged 15, sexually active and with a chaotic lifestyle which includes misusing substances has regular contact with a project 28 worker. She has also been subject to child protection plans for periods of her life. Now at college, she consulted the school nurse at the college clinic asking for contraception.*

The nurse undertook a thorough assessment, including an assessment of Fraser competency, and consulted with the CASH service as she was concerned that the young person would not attend a CASH appointment unless she could be seen quickly.

As a result of effective liaison between the school nurse and CASH, the young person was taken to the CASH clinic and had a long-acting reversible contraceptive implant (LARC) fitted on the same day.

Services demonstrated a good understanding of the requirements of a young person with a chaotic lifestyle and were flexible and proactive in meeting the young person's needs to ensure that she has effective contraceptive cover.

- 1.13 The minor injuries unit (MIU) at Paulton has good access to advice and support from staff at Royal United Hospital (RUH) or the out of hours service where advice is needed about clinical or safeguarding concerns. Cases reviewed demonstrated staff generally undertake thorough clinical and safeguarding risk assessment with prompt and appropriate referral or notifications to other agencies as appropriate. However, we did see one example of a lack of inquisitive challenge of the circumstances around one child, subject to a child protection plan, attending the MIU although children's social care were notified of her attendance.

Case examples 3 and 4:

3. *A child of six years attended the MIU accompanied by an adult other than the parent. MIU identified the child as being subject to a child protection plan from the alert notes box on the information system. The MIU practitioner documented the reasons for the child protection plan, who accompanied child and the reasons given as to why the child's mother did not attend. The practitioner also identified which school the child attended and the name of the school nurse for follow-up and the child's social worker was informed of the attendance at MIU. MIU staff were thorough in their review of this child and took appropriate action.*
4. *A child aged eight attended the MIU accompanied only by her sister. The MIU nurse identified the child as being subject to a child protection plan through an alert on the information system. Although children's social care were informed of the child's attendance for treatment, no questions were raised or documented by MIU staff regarding the accompanying sister's age or the circumstances of the incident resulting in the child seeking treatment. On this occasion, MIU practitioners demonstrated a lack of inquisitive challenge to a vulnerable child's presentation and as a result, the risk assessment was not comprehensive.*

- 1.14 At the new Urgent Care Centre provided by Northern Doctors Urgent Care (NDUC) and sited at RUH, patients including children arrive at the UCC from a variety of referral systems ensuring they are treated in the most appropriate environment. Patients may be booked in via NHS 111 or following telephone triage by a clinician. They may also be streamed to the UCC if they walk in to the emergency department (ED) or on occasion if they arrive by ambulance. An effective alarm system for a “scoop and run” approach to any sudden deterioration in a child's condition is in place. We saw some exemplar cases demonstrating thorough information gathering and risk assessment. The special notes section on the patient record should be completed either by the patient's registered GP or if information is made available to BDUC's governance department from the LSCB. We saw one case where a special note did not exist for a child. As a result of this, the UCC local clinical director is contacting local surgeries to remind them to make this information available via the SPN system where appropriate. .Assessment documentation does not have a prompt box for next of kin or who accompanied the young person, with staff free texting this information into a comments box. This increases the risk that key information may be lost and assessments not be fully informed. While GPs and health visitors are routinely notified of children's attendance at the UCC, school nurses are not receiving notifications. This could result in delayed follow-up health support to a child where the school nurse is the key health professional (**Recommendation 4.1**).

- 1.15 We saw examples of good risk assessment at the emergency department at RUH. The inclusion of a child protection screening risk assessment into the treatment card is a positive development. This steers the clinician's consideration of potential safeguarding risks and vulnerabilities and facilitates discussion of any issues with the family or accompanying adult. Where clinicians have not completed the risk assessment, this is addressed promptly with the individual clinician by the child protection lead nurse. This is ensuring that the safeguarding risk assessment of all children and young people attending the ED is becoming routine practice. Work is well in hand to improve young people's access to substance misuse services. In future, young people attending or admitted to RUH as a result of substance misuse will be referred directly to Project 28 rather than referred to CAMHS for an initial telephone screening. This will facilitate prompt engagement with the provider.

Case example 5: *child aged 7 years attended RUH emergency department following a fall at home. The ED senior house officer, in reviewing the child's previous attendances for treatment, identified an alert on the child's record. This stated that all attendances by the child should be notified to children's social care as a safeguarding concern.*

The clinician duly notified children's social care, making it explicit in his referral that he had no specific safeguarding concerns about this attendance.

- 1.16 The family nurse partnership (FNP) supports young mothers well, enabling them to achieve good personal outcomes and helping babies to thrive. In one case a mother reviewed her lifestyle, stopped risk taking, looked after the baby well and achieved a place in college. FNP support is valued by those young people engaged with the service which is reflected by the feedback the service has received. We saw evidence of ongoing identification of any worries and concerns the young person may have and also evidence that the young person is asked to think about the positives in their situation. This helps to develop the young person's confidence and to recognise the progress they are making as new parents.

Case example 6: *First time mother aged 17 years with a history of substance misuse. She is living with her partner, not in education, training or employment (NEET) and this was an unplanned pregnancy. Other than occasional visits from her mother, she was feeling unsupported and was fearful of joining any groups. The couple and new-born were under threat of eviction.*

The FNP practitioner engaged with the couple early in the pregnancy and undertook joint visits with the midwife. FNP supported the couple to obtain suitable housing and engaged the young mother in discussions on the expectation of a new-born, how to adopt a healthy lifestyle and ways to manage as new parents.

The practitioner demonstrated a good understanding of the new mother's psychological need for support when attending groups and ensured this was in place. Practice and discussions in supervision were well documented in the client record.

- 1.17 Young people experiencing emotional distress are able to access early help provision both in schools and the voluntary sector. Young people can access child and adolescent mental health (CAMHS) support promptly through the early help provision available in schools. Self-referral is available for young people who have been discharged from Tier 3 in the previous 12 months. CAMHS have plans to implement online self-referral in the near future. Good information for young people about what is available and how to access help has been developed with strong input from young people: young people involved with CAMHS have recently produced YouTube videos and leaflets. The outreach support for children and adolescents (OSCA) service provides highly effective support to young people over a 24/7 period and we saw a number of cases where young people were well supported and benefitting from therapeutic intervention. Staff report that young people being assessed for support are routinely given the opportunity to speak with practitioners without their parents being present, although this is not always explicitly demonstrated through the case record. Assessments are comprehensive, detailing the child's demeanour and practitioners' observations.

Case example 7: *Female aged 15 referred for an urgent CAMHS assessment in December 2013 due to her disclosing that she was collecting pills with an intention to commit suicide. She was assessed immediately by the OSCA team at RUH with the CAMHS practitioner liaising closely with the school.*

Over a weekend where the young person was experiencing significant emotional distress at home, there was a high level of intense home support by OSCA. A joint OSCA, CAMHS and children's social care home visit was also undertaken on Christmas Eve. The OSCA worker provided sensitive and frequent support to the young person via text messages and telephone calls. At the same time, the practitioner was providing good support to the parents, with the child's knowledge, whilst maintaining the confidentiality of the child.

This was skilled and sophisticated work by OSCA, supporting both parties simultaneously.

2. Children in need

- 2.1 Use of the common assessment framework (CAF) across health services is routine. Midwives initiate CAFs appropriately and those we saw were comprehensive. Health visitors also use CAFs well, ensuring that the most effective level of support is promptly put into place in the community. CAFs are quality assured and feedback or additional training given to practitioners as required. Records management in midwifery is poor however; with some key documents, including records of GP notifications and CAF documentation, missing from case records. Effective management monitoring systems to oversee the quality of recording practice are not in place (**Recommendation 1.2**).
- 2.2 Effective team around the child (TAC) work involving CAMHS, health visitors and other services is delivering good outcomes for individual children. TAC action plans are not always SMART however and practitioners involved in TAC need to ensure the plan makes their role clear and that progress and compliance with the plan is measurable before it is agreed at TAC meetings (**Recommendations 3.1 and 5.1**).

Case Example 8: *Male aged 16 years with ADHD and aggressive behaviour. His attendance at school was intermittent and his behaviour and aggressive outbursts at school were having a detrimental impact on his learning and that of his peers.*

His CAMHS care co-ordinator and OT saw him at home as this was an environment in which he was less distressed and more receptive. His care programme approach reviews and Team Around the Child (TAC) meetings were also held at home. The latter involved the school, school nurse, Connexions and CAMHS practitioners in a well co-ordinated multi-agency approach.

As a result of multi-agency effective support, the young person is managing his emotions more appropriately and has returned to mainstream school where he has an educational statement and is receiving 1:1 support. Planning for his transition into adult specialist support service for ADHD in Bristol is in place with the full engagement of his mother. He is also receiving support from specialist ASD workers in Sirona to ensure a smooth transition into the adult service.

- 2.3 Young people with substance misuse issues are well supported by Project 28 working in partnership with other services including the youth offending service (YOS), CAMHS and social care. With an open referral system, the service sees young people within five days and operates a partnership model with the young person's consent sought, whenever possible, to changes in case management or sharing of information with other agencies and parents. The service routinely initiates and participates in CAFs to ensure good support to young people. Practitioners are persistent in their efforts to engage young people and successful treatment outcomes are higher than the national average. Case discussions are recorded in client records as routine practice. Young people transitioning into the adult service are well supported during this difficult phase by a dedicated transitions worker who works in both services. However, the service's risk assessment does not include sufficiently probing questions about a young person's partners and relationships to ensure risks of exploitation are fully explored. CQC will draw the local authority's attention to this issue as the commissioner of this service.

2.4 Cases we reviewed in adult mental health demonstrated practitioners prioritising child safeguarding with good identification of risk and prompt referral to other support services or to children's social care where there were child protection concerns. Practitioners liaise well with other services in most cases. Effective multi-agency support to a family can result from mental health practitioners sharing expertise on an individual's indicators of mental health relapse with other professionals working with that individual. This can enable non-mental health professionals, such as health visitors, to identify early signs that a parent is becoming unwell and communicate this to the appropriate support service. The Wellness Recovery Action Plan (WRAP), utilised by AWP, is innovative; providing the mental health service user with a framework for gaining insight into their behaviours and what can trigger emotional difficulties. The WRAP includes potential relapse indicators and action plans to help them avoid emotional disturbance or support them in times of difficulty or crisis. In one case we reviewed, a mother's WRAP had been shared with all the disciplines working with her. The health visitor had found this tool highly beneficial to how she worked with the mother, enabling her to understand the mother's emotional needs and form a trusting relationship with her more quickly. AWP tell us that it is routine practice to share an individual's WRAP with other disciplines with the person's consent. However; we found a low awareness of WRAP among health visitors, indicating there is more to do to ensure this tool informs multi-agency working routinely (**Recommendation 6.5**).

Case example 9: *A mother aged 23 was a looked-after child from age 11 due to sexual abuse. She has a learning disability and continues to be supported by the complex health service team. She became pregnant in early 2013 by her long-term partner. AWP discussed with children's social care at 8 weeks and referred formally to children's social care at 12 weeks on social care's advice.*

In working with the mother to be, the mental health practitioner identified that she may pose risk to other children. AWP informed the police of these threats. Indicators of mental health relapse set out in a Wellness Recovery Action Plan (WRAP), were shared with all other professionals involved with the case with the mother's consent. This included the health visitor. The health visitor found this invaluable in working with the mother as it set out her emotional needs in her own words. This gave the practitioner good insight into how to work with the mother and they were able to develop a trusting and supportive relationship more quickly.

The baby is now living with her grandmother and the baby's mother and father have contact regularly. Mother must be with the father for contact to be unsupervised. The health visitor continues to support the child by working closely with the grandmother.

There was effective multi-agency communication and information sharing in this case, ensuring the safety of the baby while providing sensitive and effective mental health support to the mother.

- 2.5 We saw and heard case examples of children benefiting from engagement with CAMHS; becoming better able to express and manage their emotions and increasing in confidence. Clinical assessments and records of sessions are comprehensive but service plans use high level, clinical language which is difficult to link to the goals set by the child. One good, child centred assessment was let down by a lack of recording of the child's goals in the plan, which was incomplete. This makes it difficult for the clinician to clearly demonstrate the child's goals are central to the work done, to evaluate progress and for manager's to quality assure practice through the case record (**Recommendation 5.2**).
- 2.6 When young people require in-patient treatment for mental health issues, in common with many authority areas, accessing in-patient (Tier four) provision is problematic and some young people are placed at a distance from their home area. Mostly however, there is capacity within Oxford Health Foundation Trust (OHP) provision so that care is provided to the young people within the same provider trust. This facilitates seamless transition back into community based support for the young person as transition planning and communication between the hospital and community services is effective.
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3. Child protection

- 3.1 The recent Ofsted inspection found that health practitioners understood thresholds but quite high numbers of referrals are being made which do not meet children's social care thresholds for intervention. We found that health providers are generally making appropriate referrals to children's social care when they have safeguarding and child protection concerns. In most services we have seen a mixed quality of referrals however. This may, at least in part, explain Ofsted's findings. We saw an exemplar referral by an adult mental health practitioner but this was not consistent across the service. The practitioner making this referral was from a social care background which may have contributed to the clearly written expression of risk of harm to the child. Referrals reviewed in a number of services, including some seen in adult mental health and RUH, did not make the risk of harm to the child explicitly clear. Managers in AWP do not quality assure referrals and acknowledge that this is an area for development. Where referrals do not set out the risks to children clearly, children's social care's task of deciding what level of support will best support the child or family is made more challenging (**Recommendations 1.3 and 6.2**).

Case example 10: *A woman with small children attended the MIU reporting domestic violence by her partner which had been witnessed by her children. On review of patient notes, the MIU nurse identified that the GP had not placed an alert box on the screen advising of domestic violence. The MIU practitioner contacted the GP and arranged for an alert to be placed on the information system to ensure that primary care practitioners are aware of the vulnerabilities of the woman and children.*

MIU staff identified safeguarding concerns relating to the children and made an appropriate referral to children's social care and Police.

- 3.2 While children's social care have a responsibility to acknowledge referrals and inform the referrer of the outcome of the referral, we saw little evidence of health practitioners following up referrals that they had made. In some instances we were told that the practitioner had followed up by telephone but this was not recorded in the child or parent's case record (**Recommendations 3.2, 5.3, 6.3**).
- 3.3 Health practitioners are being routinely involved in child protection strategy meetings, facilitating decisions being made which are most likely to achieve an optimum outcome for the child. We heard and saw an example where the school nurse's information and understanding of the family and child issues was critical in ensuring that a case moved to an initial child protection case conference.
- 3.4 Documentation from CIN or child protection processes is not routinely scanned onto electronic case records in midwifery and adult mental health services but may be held separately. This creates a risk that practitioners cannot easily access CIN and child protection plans. In some cases, practitioners were unable to clearly identify and articulate their role in the plan although the child protection plans we reviewed generally set this out very clearly (**Recommendations 1.2 and 6.4**).

Case example 11: *A plan was put in place for a new born baby to be taken to the neonatal intensive care unit (NICU) as a place of safety. While children's social care wished this to happen immediately, midwives wanted the mother and baby to have 'skin to skin' contact prior to the baby's removal.*

The midwifery supervisory alert and communication sheet was shared with professionals and filed in the patient's notes to support the rationale for this.

All professionals were kept abreast of the latest communications.

Midwives act as good advocates for the bonding of the mother and child when there is the potential for the mother being able to care for the baby in the future, subject to decisions made at the child protection conference.

- 3.5 There is good attendance at child protection conference and core groups by health practitioners in all services. In line with best practice, it is routine for health workers across all services to submit a written report, shared with the client, in advance of child protection case conferences as well as attending in person. Health staff make clear recommendations to conference and are confident in expressing their professional assessment of safeguarding risks, when there may be professional differences with other services.
- 3.6 Practitioners told us that they rarely, if ever, see participation or reports from GPs at case conferences and this is an area identified in an SCR as requiring priority action. However, we saw some very good and committed safeguarding practice in the surgeries we visited. In one case, the GP had attended a strategy meeting on New Year's Eve which was her day off and with only 40 minutes' notice.
- 3.7 The treatment arm of the adult substance misuse service, SDAS have an identified safeguarding lead and prioritise child protection work. Identified concerns are discussed with colleagues in the developing health and independence (DHI) recovery service, safeguarding leads and social care. Specific concerns raised as a risk incident and discussed with social care are not always fully detailed in the case record and practitioners do not always ensure that they have received clear feedback on outcomes from social care. Risk assessment explores the clients' contact with children extensively beyond parental responsibility and is repeated on a three monthly basis as a minimum. This is good practice. Discussions of cases at team meetings are routinely recorded on the client's case record, although there has been a recent hiatus in this practice due to maternity cover. The practice is now reinstated.
- 3.8 There is a lack of routine and regular liaison between practitioners in the substance misuse and health visitor services outside of formal child protection processes. As these two services may be the most closely involved with a family with a vulnerable child as a result of parental substance misuse, this inter-professional liaison should be well secured. In such cases, professionals need to work with "healthy professional scepticism" when working with adults who may not be a reliable source of information (**Recommendation 3.3**).
- 3.9 Managers in the RUH ED have a clear understanding of what actions they would take if a child attending for treatment was at risk of going missing. Swipe card entry and effective use of CCTV coverage have enhanced safety and safeguarding arrangements. There is a formal policy for the identification and management of missing patients at the RUH to steer trust staff's practice and support effective liaison with other professionals. However this policy does not specifically reference children as a vulnerable group. We reviewed a CAMHS case where a young person was admitted to the paediatric ward due to risk of serious self-harm. While the CAMHS practitioner identified there was a significant risk that the child might abscond, it is unclear whether this identified risk was fully discussed by CAMHS and paediatric ward staff. (**Recommendation 1.4**).

- 3.10 Where children are at risk of harm from fabricated illness, we saw effective multi-agency working to minimise the risk of harm to the child, while working with the family in a supportive way. CAMHS' outreach service for children and adolescents (OSCA) provides a high quality therapeutic service, readily accessible to children in times of crisis. We saw a case where a young person at very high risk of serious self-harm was supported in a very child centred and creative way which was protective of personal privacy, while sensitive support was offered to the parents.
- 3.11 All health services, including adult services and the GP practices we visited, have robust non-attendance (DNA) policies in place. Practitioners were able to describe what steps they take in notifying children's social care when there is non-attendance at appointments or children subject to child protection plans are not brought to clinics and we saw case examples evidencing this as routine practice.
- 3.12 Good progress is being made in partnership with the police and AWP in ensuring that children and young people who may be subject to section 136 of the Mental Health Act are diverted from custody and have prompt access to appropriate mental health assessment from CAMHS or support in appropriate facilities. A new suite which accepts 16-18 year olds can be accessed on the Southmead Hospital site, Bristol. Placements are made there in co-operation with CAMHS and the AWP Intensive team.
- 3.13 The stand-alone information system used by CASH does not interface with other systems and therefore, unless the young person discloses that they are looked after or subject to a child protection plan, the CASH service may not be aware of the child's status (**Recommendation 2.4**).
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4. Looked after children

- 4.1 A looked after child is likely to have their health assessed initially within 28 days of coming into care as health and social care are working hard in partnership to achieve this although there is slippage on occasions. Currently performance is at 81%. The service administrator is diligent in monitoring timescales and chasing up any delayed paperwork but she has to do this by checking dates manually, rather than the IT system having an automatic alert function when delays occur. Delay is more likely to occur when a child is placed out of area and we identified a small number of cases where it was unclear whether there had been robust follow up to ensure the child's assessment and follow-up actions had been completed. (**Recommendation 3.4**).

- 4.2 Overall, initial health assessments are good quality, particularly those undertaken by the designated doctor, although some aspects of physical health assessment were not always included. The quality of assessment documentation from community paediatricians is of lesser quality, containing basic information and with little evidence of the voice and personality of the child. In one case we reviewed, the young people had had their IHA undertaken by the specialist YOS nurse rather than a paediatrician as the young person had refused to be seen by anyone else. In this instance, we concurred that this decision was appropriate; made in the interests of the young person under the particular circumstances. The multi-disciplinary discussions and considerations that took place are well documented on the child's case record. However, this is not best practice generally, as there are inherent risks that not all health needs will be identified unless the IHA is undertaken by a suitably medically qualified professional and should be avoided. The CCG designated nurse or doctor should always be consulted to ensure that all safeguarding factors are considered and that the CCG are fully involved in decision making. This did not happen on this occasion although the provider is clear that was an exception to normal practice in the service (**Recommendation 3.5**).
- 4.3 Most IHAs we reviewed did not contain detailed the child's parental or birth health histories. In some cases, it was clear that the information recorded had been gleaned from the young person rather than transferred from children's social care. We were told that where children are moving straight into adoption procedures, parental health history tends to be better secured to go with the child. The opportunity to collect this information only occurs when the child first comes into care. Unless this information is efficiently transferred to the looked-after children's health team to be entered onto the IHA record, there is a high risk that this information will not follow the child's journey through care. Many care leavers tell us of the long-term impact of not having their birth or parental health history as they enter adulthood. This is a key area for development across the partnership (**Recommendation 3.6**).
- 4.4 Review health assessments reflected the voice and individuality of the child and most were detailed and linked to previous assessments. We did see some RHAs however which were episodic and did not pick up on previous identified health issues. The team is developing and piloting new documentation which they expect to better support practitioners in delivering good quality assessments. Whenever possible, the looked-after children's nurse or specialist school nurse undertakes health reviews for a child placed out of area, ensuring that the service knows most children in care over a longer period of time, well and providing continuity for the child. Health plans developed from the health assessments are not yet routinely SMART although of improved quality since our previous inspection. Accountabilities are set out and for the most part, plans include measurable objectives although we saw some examples where this wasn't the case. Timescales are also not always sufficiently specific (**Recommendation 3.7**).

Case example 12: *A group of three siblings placed in an out of area placement, 35 miles from BaNES. Their review health assessments were undertaken by the BaNES specialist school nurse in their placement.*

This enabled the children to have their health reviewed in a setting in which they were comfortable. It also facilitated good communication about the children's individual health needs between the looked-after child health team and carers in the out of area placement.

- 4.5 GP's are not always receiving copies of looked-after child health assessments and we found examples of this in our visits to GP practices. In our visit to CAMHS we reviewed a case where, although OSCA had been instrumental in providing recent health support to a young person and had important knowledge and understanding of her emotional health needs, the service had not been asked to contribute to her IHA. As a result, the paediatrician undertaking the assessment did not have all necessary information to ensure a comprehensive assessment. We were told that CAMHS generally do not have input into looked-after children's health assessments (**Recommendation 3.8**).
- 4.6 One foster carer told us of difficulties she had when looking after a child with complex health needs who had appointments a few days apart with different consultants at RUH. The child's notes from the first consultant had not transferred through the hospital information system. As the second consultant did not know the child and could not access all the current information, the foster parent was concerned that the second consultation was not fully informed. Co-ordinating appointments for children with complex needs to reduce the pressures on carers and ensure clinicians are fully informed of the child's current treatments is challenging but when achieved, carers tell us how much more beneficial this is for the child. When three siblings moved foster placement and GP practices, while the medical records for the two siblings with significant health needs were transferred to the new practice, those for the third, healthy child were not. This oversight was picked up when an observant health visitor noticed that the surgery had no records for the third sibling. When children are engaged with different hospital services or looked after children move placement, the child is put at risk if safeguards are not put in place to ensure that all relevant information and documentation has been uplifted between hospital services or transferred between GP practices (**Recommendations 1.5 and 3.9**).
- 4.7 While the looked-after child health service is not commissioned to support young people beyond the age of 18 years, support is given to some young people where there is a particular need identified. The use of the care leavers' health passport, developed by Cornwall and the Isles of Scilly is a very positive development and the looked-after children's nurse is keen to develop its use further in consultation with the young people.

- 4.8 Looked after children and care leavers have good opportunities to inform and influence the development of health support to young people in care. They meet regularly with the looked-after children's nurse who attends the Children in Care Council and its various sub groups on a regular basis.

Case example 13: *A male reaching 18 in March 2014 had his final health review in October 2013. This was undertaken by the looked-after children's nurse at Project 28, substance misuse service, at the young person's request, where he was receiving support due to his use of cannabis.*

The review focused on his experiences and brought out the voice of the child well. The looked-after children's nurse liaised with the youth offending service which was also working with the young person and communicated well with his GP about his on-going health issues. The nurse ensured that appropriate support for his long-term health needs was in place.

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 It is clear that partner agencies have used the findings and judgements of the 2012 joint Ofsted/CQC inspection positively, to develop a shared improvement agenda and all partners have made significant strides towards its delivery. The joint commissioning arrangements facilitate an effective partnership approach. The CCG has worked with providers to support them in recognising and understanding their roles and responsibilities in safeguarding and joint commissioners are bringing a greater focus on safeguarding in contracts; holding providers to more rigorous account for delivery. The CCG has prioritised the provision of effective safeguarding and looked-after children's health arrangements in its first year of operation. This commitment is well demonstrated by the CCG's early commitment of resources into the establishment of a clear safeguarding and looked-after children's infrastructure.

- 5.1.2 Designated roles have been established or revised and experienced post holders appointed with additional capacity enabling them to include developmental work in their roles. The designated doctor role has moved from one session per week to three, creating capacity in the role to deliver a developmental agenda which the new post holder is currently developing. The transfer of the role from the outgoing designated doctor to the new incumbent, was achieved seamlessly with an effective handover process.
- 5.1.3 Health are members of the corporate parenting board and attend all appropriate LSCB groups. Children who become looked after can expect to have their health needs supported by a service much improved since January 2012 with an approach that is more systematic. Designated doctor and nurse roles are in place and there is a clear infrastructure and accountabilities. The provision of a part-time specialist school nurse role in Paulton where a cohort of BaNES looked-after children are placed is positive, giving these children prompt access to specialist support. The looked-after children's nurse and specialist nurse are well supported to undertake their roles and the looked-after child health team have a clear improvement agenda which they are working on in partnership with social care. Regular meetings take place between the team and a senior manager in social care to oversee service delivery, drive improvement and resolve difficulties. The team see this as a valuable and productive forum. CAMHs' planned attendance at future meetings will further strengthen looked-after children's health governance. This will facilitate the whole system approach which is developing across the key agencies supporting looked-after children and foster carers.
- 5.1.4 All health agencies are appropriately engaged with the work of the LSCB and its sub-groups. Close connection between the LSCB and adult safeguarding board is facilitating the embedding of Think Family practice in adult health services.
- 5.1.5 There is good engagement between the CCG and NHS England with regular meetings and a recently agreed memo of understanding which sets out how these agencies will work co-operatively: the agreement that CCGs will hold resources and take the lead for safeguarding training and advice to GPs provides a clear basis to move GP safeguarding practice forward. The Area Team's safeguarding leads forum is established, well attended by most relevant BaNES safeguarding leads and developing its agenda of priorities. Quality Surveillance Groups are seen as a positive forum through which to share intelligence on commissioning issues.
- 5.1.6 A clear Children and Young People's Plan 2014-17 is in place; young people are engaged in monitoring the delivery of the strategy. As a result of additional resources being given to schools support to young people on emotional and sexual health has been strengthened. These support programmes include peer mentors, known as *Worry Busters*, and *Little Tin of Worries*.

- 5.1.7 The designated safeguarding nurse is providing effective leadership across the health community, providing good and valued support to named nurses and safeguarding leads. The BaNES named health professionals safeguarding children network is led effectively by the designated nurse. Participants tell us this is a valuable forum in which to discuss common issues, explore case examples and share good practice. SDAS do not have a good understanding of the designated and lead safeguarding roles beyond those within AWP. The service's safeguarding lead is not engaged with the local named nurse network or NHS England Area Team safeguarding leads forum which they told us they would welcome.
- 5.1.8 The newly appointed named GP is highly motivated and has a clear understanding of the role and the priority areas for development in primary care. She is currently undertaking a review of training to ensure GP's receive safeguarding training in accordance with intercollegiate guidance. GPs we met recognised the additional leadership and support the named GP role will bring; driving improvement in primary care's engagement with child safeguarding arrangements. The designated nurse has set up a general practice safeguarding leads forum which meets on a quarterly basis. She will continue to jointly facilitate this with the named GP and designated doctor. The named GP is giving priority to working across the partnership to improve GP attendance or participation in child protection conferences. To date, she has worked successfully with children's social care. This is exemplified in a child protection case conference being held at the practice in which she is based, enabling the child's GP to attend.
- 5.1.9 There is clear evidence of significant improvement in children's safeguarding practice in the emergency department at RUH. Recommendations from the previous inspection have been addressed and good safeguarding systems and processes have been put in place. These systems are subject to regular review and refinement with a recent change to include the identification of whether the young person is known to children's social care or a looked-after child. A twice weekly review of all under 18 attendances has been established and governance arrangements are in place. Safeguarding activity is routinely reported to the trust's safeguarding children committee and specific activity is also escalated to senior managers and the director with board responsibility for safeguarding children. Where a child has attended the ED three times, the case is automatically reviewed by the child protection lead nurse. This is good practice.
- 5.1.10 AWP has reshaped its service infrastructure into local delivery units. In BaNES this is facilitating the development of stronger local partnerships. AWP managers told us that this organisational change is leading to improved relationships and more cohesive and co-operative working with children's social care.

5.2 Governance

- 5.2.1 AWP is making positive progress in establishing a Think Family model across adult mental health services in BaNES. New assessment and supervision processes and documentation have been developed to further steer and support effective practice, although some of these have not yet been introduced. More work is needed to ensure that areas for development for AWP identified in previous CQC CLAS reviews are addressed in BaNES as some similar issues have been identified. Where cases are discussed in supervision, there is no record of the outcomes of these discussions on the clinical record in line with best practice. AWP practitioners in adult mental health and the substance misuse service SDAS, also told us that they do not always record case activity and discussions with other professionals on the client's record. As a result, the audit trail of practitioner actions is incomplete. This makes it difficult for operational managers to monitor practice effectively through case recording. This was identified in a previous CLAS review as an area for development. AWP senior managers took prompt action during this review to ensure that operational managers and teams are aware of their responsibilities; that lessons have been learnt from previous CLAS reviews and that best practice becomes routine **(Recommendations 6.1)**.
- 5.2.2 In AWP, plans are in hand for all invitations to child protection conferences and meetings to go from children's social care to a central AWP administrator to ensure that invitations go to the correct practitioner in the right team. This central administrative point will also receive all AWP practitioner child protection reports facilitating the establishment of a consistent and robust quality assurance process. These new arrangements are to be introduced in July.
- 5.2.3 The RUH developed an action plan from the December CQC Wave 1 hospital inspection; is working closely with CQC hospital inspectors and is making progress on the improvements required. This includes ensuring that children are observed effectively while in the ED and to ensure a pathway is established to move children promptly onto the paediatric ward in times of pressure in the ED. The trust's board receives regular reports on progress on the delivery of the action plan.
- 5.2.4 Prompt remedial action was taken at RUH when an IT problem was identified. This problem had resulted in notifications of attendance not being automatically sent to primary care and community services as expected. All cases affected were reviewed promptly to ensure that no child had been put at risk and that health needs were being met effectively.

- 5.2.5 BDUC has identified a difficulty in migrating information about known child safeguarding concerns from the previous provider. The BDUC is taking appropriate and prompt remedial steps to mitigate any risk that important information may be lost concerning individual children. Good communications have been developed between the BDUC clinical director of the UCC and the RUH ED. UCC clinicians are able to consult all specialities at RUH promptly regarding any paediatric clinical concerns and fortnightly meetings take place between UCC and the matron and administrative lead for the ED.
- 5.2.6 At the UCC, when safeguarding issues are identified the practitioner will seek advice from or refer to the local safeguarding team promptly and will notify BDUC governance department at the same time so that, if appropriate, a special note can be added to the system. However, as the governance team receive notifications of safeguarding alerts from the LSCB only on a fortnightly basis, there may be up to two weeks delay on the special note being added. If the child attends the UCC within this timespan, practitioners may not be aware of a previously identified concern as the information system is not up to date (**Recommendation 4.2**)
- 5.2.7 Practitioners at the MIU are alerted to a child's previous attendances at the service and any known concerns, including whether the child is known to be subject to a child protection plan through effective flagging on the information system. However, initial registration and assessment documentation does not include fields for who has accompanied the child in order to ensure this information is ascertained and any resultant safeguarding concerns routinely considered. We did review a case where this had resulted in a less than robust risk assessment. The secondary review of all documentation for children who have attended the MIU, undertaken by the school nurse or health visitor, helps to ensure that all vulnerabilities and safeguarding concerns are identified. (**Recommendation 3.10**)
- 5.2.8 The accuracy and comprehensiveness of case recording is a priority area for development in a number of providers, including the midwifery service where some records lacked CAF documentation due to records being archived inhibiting practitioners ability to ensure all current documentation is available on the client record. We saw a number of case examples in CAMHS and community health where practitioners' descriptions of contacts or discussions with service users or other professionals are not reflected accurately or not recorded in the case record. This is of concern. Practitioners and managers may be unable to assure themselves that risk assessment is comprehensive, decisions are fully informed and consequently ensure that children are kept safe. We have also seen little evidence in case records of managerial oversight or auditing of case recording as part of their practice quality assurance monitoring. In the CAMHS service for example, while the team manager does undertake quarterly audits of a sample of cases, this is not noted in the individual clinical record (**Recommendations 1.2, 2.2 and 5.4**).

- 5.2.9 Multi-agency work to address child sexual exploitation is progressing positively. A risk panel has been set up with key partner agencies, including the sexual health lead doctor from the CASH service. This will facilitate effective information sharing on young people deemed to be at risk.
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5.3 Training and supervision

- 5.3.1 All health providers who have attended the safeguarding supervisor training have found this very useful in helping them to make progress in establishing effective supervision arrangements.
- 5.3.2 Safeguarding supervision arrangements are well established in Sirona community health services and all practitioners are trained to level 3. Family nurse partnership practitioners are particularly well supported, receiving weekly supervision from their supervisor and quarterly supervision from the named nurse. In addition, they have monthly individual sessions with the psychologist and with peers as required. Where a case is discussed in supervision, this is documented on the case record in line with best practice.
- 5.3.3 Midwives at RUH have not undertaken safeguarding training to the required level and this and the provision of effective supervision arrangements remain areas for development. Progress on establishing robust safeguarding supervision arrangements has been slow since the 2012 joint inspection. Ad hoc supervision is available which is recorded on the supervision sheet and retained in the client notes and four midwives have undertaken supervision training. However, currently only specialist midwives receive one-to-one supervision on a quarterly basis with other midwives having group supervision on a six monthly basis. Given the role of the midwives and the range of safeguarding issues and vulnerabilities for both adults and children that they deal with on a day-to-day basis, this is not sufficient to ensure practitioners are properly supported. Managers in the midwifery service acknowledge that training is also required on CSE and FGM to ensure that practitioners are fully equipped to identify where these issues may affect the women in their care (**Recommendations 1.6 and 1.7**).

- 5.3.4 Staff in the MIU are supported well by Sirona to access training relevant to their role in providing effective clinical treatment to children and young people. The safeguarding link nurse role within the service is also valued in sharing current safeguarding information. However, the level 3 safeguarding training that has been provided is modular in its approach and is not multi-agency. Given the nature and range of adults and children accessing this service this is not sufficient to ensure staff are fully equipped and knowledgeable. CASH staff safeguarding training is also an area for development to ensure that practitioners are fully supported in their roles. Safeguarding supervision arrangements are not in place at MIU as there is no individual supervision and the service is aware that this is a priority area for development to ensure that staff are fully equipped and supported to discharge their safeguarding responsibilities. At CASH, effective safeguarding supervision arrangements are not in place and therefore, the lead nurse is not fully supported in her role. (**Recommendations 2.3 and 3.11**).
- 5.3.5 Some staff at the UCC are not trained to level 3 as recommended in *Safeguarding Children and Young People: roles and competences for health care staff: Intercollegiate Document, March 2014*. BDUC managers in the UCC service have told us that this is a priority area for development and that action is being taken to facilitate this. (**Recommendation 4.3**).
- 5.3.6 At RUH, ensuring the provision of sufficient paediatric trained staff at all times in the ED remains a challenge and is included in the trust's Wave 1 action plan. The trust ensures practitioners develop their skill set through the provision of advanced paediatric life support training and is developing six month rotation of staff from the paediatric ward into the ED. Robust safeguarding supervision arrangements are being implemented; these are not yet fully embedded however and remain an area for development. Trust safeguarding leads and managers are giving priority to the development and further implementation of an appropriate model (**Recommendation 1.8**).
- 5.3.7 In AWP mental health service, managers report that 100% of the intensive team practitioners and overall, 92% of all AWP practitioners are trained to level 3 for child safeguarding against a target of 90%. Work is in hand to bring all psychiatrists, including those working in older people's services up to intercollegiate guidance level. Currently, LIFT practitioners are trained to level 2. AWP feel this is commensurate with their roles and responsibilities but the service is new and this will be reviewed as the impact and effectiveness of the service is reviewed. Case examples from the service will inform this review.

- 5.3.8 AWP is working to strengthen supervision arrangements as this has been identified previously as an area for development for the trust. A new model of supervision is being piloted by AWP in Wiltshire and is likely to be rolled out across all AWP teams. AWP managers expect this to ensure more robust child safeguarding supervision arrangements for individual practitioners. In BaNES, the manager of the recovery team has introduced a new model of red, amber, green (RAG) rated safeguarding risk assessment for cases which informs supervision discussions. This is very new however and no examples were seen at this review.
- 5.3.9 The CAMHS service operated by OHFT have effective clinical and safeguarding supervision arrangements in place. Senior staff within the service attended the multi-agency supervision training and the follow-up review meeting convened by the designated nurse to evaluate the impact of the training. One outcome from this is that where practitioners seek ad hoc advice and guidance on safeguarding issues in individual cases, this is being recorded on the client record.

Recommendations

- 1. Bath and North East Somerset CCG and Royal United Hospital NHS Trust should:**
 - 1.1 In partnership with Wiltshire CCG, ensure that midwives see mother's to be on their own to facilitate disclosure of any risk factors including sexual exploitation and domestic violence; that the identity of the person accompanying her is recorded and that assessment documentation fully promotes and guides good practice.
 - 1.2 In partnership with Wiltshire CCG, ensure that a high standard of case recording practice is maintained in the midwifery service and that all key plans and documents are held on the case record.
 - 1.3 Ensure that safeguarding referrals made to children's social care articulate the risks to the child or young person clearly; facilitating effective decision making that ensures the child is safeguarded and well supported.
 - 1.4 Ensure that there is an effective policy and protocols in place at the acute hospital to reduce the risk of children and young people going missing or absconding; this should be in line with the LSCB multi-agency policy.
 - 1.5 Ensure that where children with complex needs may be seen by different consultants or different hospital services, that appointments are co-ordinated whenever possible and that medical information about the child is secured promptly within the hospital information system.
 - 1.6 In partnership with Wiltshire CCG ensure that all midwives undertake comprehensive training commensurate with their roles and responsibilities; this should include multi-agency level 3 safeguarding training in line with statutory and intercollegiate guidance.
 - 1.7 In partnership with Wiltshire CCG, ensure that all midwives are well supported in their role through the provision of regular, planned and recorded supervision as set out in statutory guidance.
 - 1.8 Ensure that staff in the emergency and paediatric departments are well supported through the provision of robust safeguarding supervision arrangements in line with statutory guidance.

2. Sirona Care & Health should:

- 2.1 Ensure that practitioners in the contraception and sexual health services routinely incorporate their observations and details of the young person's demeanour in assessments and that the proforma is effective in promoting good risk assessment.
- 2.2 Ensure that case recording practice is of consistent good quality, enabling practitioners and managers to access current information about a child or young person.
- 2.3 Ensure that staff in the contraception and sexual health service undertake safeguarding training to a level appropriate to their role and that they receive regular and robust safeguarding supervision in line with statutory guidance.
- 2.4 Explore with partners, systems through which contraception and sexual health services can identify whether young people attending the service are subject to child protection plans or are looked after.

3. Bath and North East Somerset CCG and Sirona Care & Health should:

- 3.1 Ensure that where team around the child (TAC) plans are put in place, the plan defines the practitioner's role clearly and that the practitioner is able to monitor the client's compliance with their service's element of the plan.
- 3.2 Ensure that when safeguarding referrals are made to children's social care, practitioners ascertain the decision and record this on the case record.
- 3.3 Ensure that community health practitioners have direct and regular communication with adult substance misuse services in cases where both services are working with a family, sharing information and expertise to ensure effective co-operative practice.
- 3.4 Ensure that for looked-after children, including those placed out of area, there is robust monitoring to ensure that health assessments and follow-up actions have been completed.
- 3.5 Ensure that designated professionals are consulted if the undertaking of an initial health assessment of a looked-after child by a practitioner other than a consultant paediatrician is being considered under exceptional circumstances.
- 3.6 Work with the local authority to ensure that looked-after children's parental and birth health histories are ascertained whenever possible as the child comes into care and inform the initial health assessment, enabling this information to follow the child's journey through care.

- 3.7 Ensure that health plans developed from looked-after children's initial and review health assessments are SMART; setting out measurable objectives and specific timescales to ensure children's identified health needs are met promptly.
- 3.8 Ensure that GPs and specialist health services working with the child are routinely invited to contribute to the child's initial or review health assessment and that the child's GP receives a copy of the assessment.
- 3.9 Work with the local authority to ensure that when looked-after children move foster or residential placement, medical information is transferred or communicated effectively between health services.
- 3.10 Ensure that safeguarding risk assessment at the minor injury units is robust and that practice is well supported by comprehensive documentation.
- 3.11 Ensure that the lead safeguarding nurse and staff at the minor injury units and CASH service are well supported in their role through the provision of appropriate safeguarding training and regular, planned and recorded supervision.

4. Bath and North East Somerset CCG and Bath and North East Somerset Doctors Urgent Care Ltd (BDUC) should:

- 4.1 Ensure that practitioners at the urgent care centre undertake comprehensive assessments of adults and children attending for treatment and that all appropriate services are duly notified.
- 4.2 Ensure that systems, processes and documentation are put in place to support effective safeguarding practice, subject to robust management oversight.
- 4.3 Ensure that all staff at the urgent care centre undertake child safeguarding training to a level commensurate with their roles and responsibilities.

5. Bath and North East Somerset CCG and Oxford Health NHS Foundation Trust should:

- 5.1 Ensure that where team around the child (TAC) plans are put in place, the plan defines the practitioner's role clearly and that the practitioner is able to monitor the client's compliance with their service's element of the plan.
- 5.2 Ensure that service plans guiding practitioners' direct work with children link clearly to the goals set by the child or young person and make use of accessible language.
- 5.3 Ensure that when safeguarding referrals are made to children's social care, practitioners ascertain the decision and record this on the case record.

- 5.4 Ensure that recording practice is robust and subject to regular managerial oversight; all key documentation is scanned onto the electronic record and all actions taken by practitioners are entered onto the case record.
- 5.5 Ensure that where CAMHs is working with a looked-after child, the service contributes to the child's initial and review health assessments to help ensure that these are comprehensive in relation to the child's emotional journey.

6. Bath and North East Somerset CCG and Avon and Wiltshire Mental Health Partnership NHS Trust should:

- 6.1 Ensure that when discussions of cases take place in practitioners' supervision, these and the decisions taken are recorded on the client record.
- 6.2 Ensure that safeguarding referrals made to children's social care articulate the risks to the child or young person clearly; facilitating effective decision making that ensures the child is safeguarded and well supported.
- 6.3 Ensure that when safeguarding referrals are made to children's social care, practitioners ascertain the decision and record this on the case record.
- 6.4 Ensure that recording practice is robust and subject to regular managerial oversight; all key documentation is scanned onto the electronic record and all actions taken by practitioners are entered onto the case record.
- 6.5 Work with partner agencies to expand the understanding and use of Wellness and Recovery Action Plans (WRAP) in providing effective multi-agency support to vulnerable families.

Next steps

An action plan addressing the recommendations above is required from Bath and North East Somerset 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.