

# **Review of health services for Children Looked After and Safeguarding in South Gloucestershire**

# Children Looked After and Safeguarding The role of health services in South Gloucestershire

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<b>CCGs included:</b>	South Gloucestershire CCG
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## Contents

<b>Summary of the review</b>	<b>3</b>
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
<b>The child's journey</b>	<b>8</b>
Early help	8
Children in need	18
Child protection	22
Looked after children	28
<b>Management</b>	<b>31</b>
Leadership & management	31
Governance	36
Training and supervision	40
<b>Recommendations</b>	<b>44</b>
<b>Next steps</b>	<b>47</b>

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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in South Gloucestershire. 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 South Gloucestershire, 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.

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## About the review

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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 2015*.
- 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.

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## How we carried out the review

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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 77 children and young people.

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## Context of the review

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*The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within South Gloucestershire. The average score per child in 2014 was 15.1. This DfE score is considered to be borderline cause for concern and is above the England average of 13.9. The average score over the past two years has been increasing which suggests that the emotional health and wellbeing of looked after children in South Gloucestershire may be worsening.*

*In 2014, the DfE reported that South Gloucestershire had 115 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). As of March 2015 there were 174 looked after children in South Gloucestershire, this from a 0-19 population of 64,000. In March 2015, 174 children were also subject of a child protection plan. In 2014 the DfE reported that 87% received their annual health assessment which is slightly below the England average of 88.4%. 82.6% of looked after children had their teeth checked by a dentist which also below the England average of 84.4%. As at 31 March 2014, there were 20 looked after children who were aged five or younger, the DfE report that all of these children had up to date development assessments.*

*5.7% of South Gloucestershire's population is estimated to be from a Black and Minority ethnic (BME) group around half the national average.*

*Commissioning and planning of most health services for children are carried out by South Gloucestershire Clinical Commissioning Group*

*Commissioning arrangements for looked-after children's health are the responsibility of South Gloucestershire Clinical Commissioning Group and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by North Bristol NHS Trust*

*Acute hospital services are provided by North Bristol NHS Trust (16-18) University Hospitals Bristol NHS Trust (under 16) and Royal United Hospital Bath (0-18)*

*Yate MIU Yate MIU is commissioned by South Gloucestershire Clinical Commissioning Group*

*Community based services are provided by North Bristol NHS Trust and in partnership with Barnardo's (Community Children's Health Partnership)*

*Health visitor services are commissioned by South Gloucestershire Local Authority and provided by North Bristol NHS Trust*

*School nurse services are commissioned by South Gloucestershire Local Authority and provided by North Bristol NHS Trust*

*Child and Adolescent Mental Health Services (CAMHS) are provided by North Bristol NHS Trust*

*Child substance misuse services are commissioned by South Gloucestershire Local Authority Public Health Department and provided by Young People's Substance Misuse Service*

*Adult substance misuse services are commissioned by South Gloucestershire Clinical Commissioning Group and provided by Avon and Wiltshire Mental Health Partnership NHS Trust.*

*Contraception and sexual health services (CaSH) are commissioned by South Gloucestershire Local Authority, Public Health Department and provided by University Hospitals Bristol NHS Trust*

*The New Horizon specialist mental health mother and baby unit at Southmead Hospital is provided by Avon and Wiltshire Mental Health Partnership NHS Trust*

*Specialist facilities are provided by (section 136) Avon & Wiltshire Mental Health Partnership NHS Trust*

*The last inspection of health services for South Gloucestershire's children took place in June and July 2012 (report published in August 2012) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.*

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## The report

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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.

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## What people told us

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We spoke with the husband and father of a mother and baby currently receiving care and support on the New Horizon mother and baby unit. He told us:

*"Without this unit my wife would have ended up on a general psychiatric ward. She would have been separated from our child and that would have just made things so much worse. This place is fantastic, the staff are great and I am kept up-to-date on everything that is going on. My wife is doing so well here and our baby is just as well looked after. I can't fault it".*

We spoke with a mother on the midwifery ward at Southmead hospital. She told us:

*"My care was absolutely amazing, the NHS at its very best. The nursing staff are amazing, everyone is really helpful".*

Her partner went on to tell us:

*"We are beyond pleased with the care we have received".*

We spoke with a young couple who had experience of the 'family nurse partnership'.

*"My confidence needed to be built when I entered the service. As a young parent you can feel judged for this by others. My confidence has increased through this programme."*

We spoke with people currently using services offered by the health visiting team. They told us:

*"They don't rush you, it's not just a case of getting baby weighed and then having to rush off, they always ask if you have any questions".*

*"They've been really helpful and always take the time to sit down and talk things through"*

*“I liked the home visits. They were really nice as a new mum”.*

*“When I have asked for help I have got it”.*

One person we spoke with at health visiting services told us:

*“They need tea, biscuits and cake at the breast feeding clinic please”!*

We spoke with an experienced foster carer who told us:

*“The looked after children’s doctor is very helpful. If ever I need help or advice I call, leave a message and she gets straight back to me. The same goes for the looked after children’s nurse. I have never been made to feel like anything is my fault, it’s a very good service”.*

We asked the foster carer about children’s initial and review health assessments. They told us:

*“They are always very positive. I am given plenty of notice to fill out the paperwork before the review takes place and they are never cancelled. They are detailed and I always get plenty of useful information from them, including who is tasked to do what to support the child and that includes me”.*

The foster carer went on to tell us:

*“I have found health visitor experiences a bit varied over time. I had a child who was returned to their parent for a period of time and I noted that when the child was returned to my care that they had lost weight and were generally less healthy than when they left. I heard that the child was not weighed once when in the care of their parent because the child was asleep and the health visitor didn’t want to disturb them. I think that if the child had been weighed then they would have noticed the weight loss earlier”.*

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## The child's journey

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

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### 1. Early help

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1.1 Children and young people attending the emergency department (ED) at Southmead hospital do not benefit from having a full safeguarding assessment undertaken. The current IT system used for the ED record does not include appropriate safeguard triage prompts for staff members to follow. In all records seen we saw evidence that health professionals were asking if social care were involved with the family but other information, as recommended by the National Institute for Health and Care Excellence (NICE), was not recorded. There are no prompts to remind professionals to explore potential non-accidental injury and practitioners are not recording if these issues have been adequately explored. This is further compounded by the fact that safeguarding questions can only be accessed when the practitioner has already identified child protection concerns, rather than the triage identifying the concern in the first place (by ticking the yes box to the question, "Are there any safeguarding concerns identified?")

Although we were advised by staff that this situation will not be resolved with the expected introduction of a new electronic patient record system we have since been assured that this is not the case and that the issue has now been resolved on both the old and new electronic systems. Consideration needs to be given to implementing a formal remedy in the long term however. (**Recommendation 1.1**)

1.2 Children and young people attending the children's ED at Bristol Royal Hospital for Children (BRHC) are benefiting from good comprehensive assessments of risk using dedicated under 16s admission paperwork. At the booking in stage, reception staff will gather and collect information of basic demographic details, including those who accompanied them to the department. This is important information as not recording who accompanied children and young people has featured in serious case reviews. Recording information on basic demographics can also help ensure that practitioners are able to provide culturally sensitive care and support.

1.3 Where ED practitioners at BRHC have concerns regarding the safety of children and young people, these are being appropriately discussed at staff 'cause for concern meetings' and information is being shared in a timely manner with children's social care.



1.4 We saw that at BRHC ED attention is particularly paid to potential vulnerabilities for non-mobile babies. We were informed that a new 'immobile baby protocol' was recently introduced by the local safeguarding children board. Although we were informed that there have been challenges in fully embedding the protocol the practice is currently under review in order to make any required improvements to increase its effectiveness.

1.5 Children and young people attending the children's ED at BRHC benefit from a detailed safeguarding risk assessment, which includes questioning around risk-taking behaviour including, for example, drug and alcohol misuse. This means that ED practitioners will be able to assess any additional vulnerabilities for children and young people who may be at risk of child sexual exploitation (CSE).

1.6 All children and young people attending the ED at Southmead hospital first book in with the reception staff where basic demographic details are obtained, along with who has accompanied them. However, reception staff are not routinely obtaining the name of the parents, instead recording 'mum, dad or parents'. This is important information and poor recording of who is accompanying the child often features in serious case reviews. (**Recommendation 1.2**)

1.7 Children who attend the ED at Southmead hospital do not have their attendances reviewed by paediatric liaison and reliance is placed on ED practitioners completing a paediatric notification form where there are concerns that do not meet the threshold for children's social care but that need to be brought to the attention of a health visitor or school nurse and GP. However, we saw how these forms were being used appropriately and that they are subject to regular audit.

1.8 There is also no paediatric liaison nurse in the children's ED at BRHC. However, admission paperwork for all children who attend the department between 10pm and 8am, including those who did not wait for assessment or treatment, is reviewed by the paediatric consultant within 48 hours of attendance. In the absence of a paediatric liaison nurse this provides some assurance that those attendances have benefited from an independent review by a senior clinician. We are also informed that admissions paperwork is subject to regular audit.

1.9 The dedicated children and young people's waiting area at BRHC ED is very much orientated to younger children. Children and young people attending the children's ED are treated in a 12 bed department which has two separate cubicles for young people. However, one of the beds is also used for infection control reasons which means that there is not enough confidential space to discuss more sensitive issues or to treat children or young people who attend in a mental health crisis.

There are two resuscitation bays with the potential for a third. However, the space is very limited and this may be of a concern as BRHC is now a trauma centre. Practitioners recognise the limitations of the children's ED at BRHC and confirm that they are hindered by the physical environment and space in which they have to work. (**Recommendation 2.1**)

1.10 All young people aged between 16 and 18 are routinely seen in the adult ED at BRHC and are not given a choice of whether they would rather be seen in the children's department for assessment and treatment. There is also no separate admission paperwork for this age group within the adult care environment. The absence of dedicated paediatric paperwork means that the additional vulnerabilities of this age group may be missed in an adult care environment. (**Recommendation 2.2**)

1.11 Children and young people are able to access limited urgent care from the emergency department at Southmead hospital. The department is commissioned to provide a minor illness and minor injury service and all children who need ambulance transport are sent directly to BRHC. Children are seen quickly at Southmead hospital by triage and once assessed wait for treatment in a dedicated paediatric area that is separate to the adult area. Older young people are given the choice where they wish to wait for treatment.

Children are treated in a dedicated cubicle space that is bright, friendly and well equipped. One cubicle has a 'Daisy Bus' which is a specially adapted stretcher, made to look like a bus, with steps leading up to it. There is a dedicated paediatric resuscitation space within the department's resuscitation area and staff have quick access to treatment guidelines and protocols for use in an emergency.

1.12 Adults who attend the Southmead hospital ED and disclose domestic violence are able to access an Independent Domestic Violence Advisor (IDVA) and there are dedicated domestic violence links within the ED department to provide advice and guidance. Having such access improves the chances of identifying vulnerable children and young people living in families where domestic violence takes place.

1.13 The waiting room at Yate Minor Injuries Unit (MIU) is a large space with a small area containing some children's toys. There is no separate children's waiting area and the waiting room is shared with adults waiting for treatment or other services. The waiting room is not monitored or directly observed by staff from the MIU or members of the administrative team. However, treatment rooms were seen to have decorative pictures on the walls of cartoon characters and diversional toys were available.

1.14 Systm1 is the IT system used to record attendances at the Yate MIU as provided by Sirona Care and Health. All records for young people aged 18 and under are printed and faxed to all relevant professionals such as GPs, health visitors, school nurses and social workers within 24 hours of the attendance taking place. Records examined were seen to be comprehensive, detailed and individualised. Where age appropriate, history was taken directly from the child or young person in attendance and this was also clearly documented. A 'primary care notification form' was also seen in notes examined. This is used to highlight issues to the primary care team where instigation of early help services would be beneficial.

1.15 A safeguarding children template is included within the electronic patient notes in use at Yate MIU and this information is forwarded to wider health services on completion. In notes sampled, we saw that the form clearly states who attended with a child, their relationship, and that safeguarding had been considered. However, the template used is not robust as completion of fields is not mandatory, and in cases examined important safeguarding information had been omitted. We could not therefore, be assured that safeguarding questions had been asked. We were advised that compliance on completion of the template is audited and monitored. **(Recommendation 9.1)**

1.16 We were told, and saw in notes sampled at Yate MIU, that it is not routine practice to ascertain if an adult attender, especially those who attend having undertaken risky behaviours such as substance misuse or self-harm, have caring responsibilities or access to children and young people. Currently this information may be gathered on an ad-hoc basis reliant on staff professional curiosity. This is a missed opportunity to 'think family' and consider the impact of parental ill health or lifestyle choices on any children and young people to whom they may have access. There is an adult safeguarding proforma on Systm1 which addresses issues such as assault and domestic abuse which could be expanded and made more robust to link with safeguarding children issues. **(Recommendation 9.2)**

1.17 At the Yate MIU, safeguarding notices in the waiting area inform parents and carers that certain information will be gathered which could be shared with other professionals, including children's social care, as a matter of routine.

1.18 There is currently no formal process at Yate MIU to follow up children or young people who attend the unit, book in but then do not wait and leave before being seen and assessed. We were advised that GPs, school nurses and health visitors are informed and we were further informed that a formal follow up process is under development. **(Recommendation 9.3)**

1.19 Staff at Yate MIU have limited links to other MIUs and EDs so as to be in a position to readily examine a person's previous attendances other than at those units managed by Sirona Care and Health. We saw evidence of staff asking attendees if they had attended an MIU or ED within the last year, but they are reliant on voluntary disclosure which might not be forthcoming. Staff mitigate this as much as possible by ensuring that details of attendances are always passed to GPs, health visitors and school nurses for all under young people aged 18 or under.

1.20 The absence of an integrated shared electronic record keeping system prevents Yate MIU and other services from accessing and recording safeguarding information directly into the health record of the 0-19 population of South Gloucestershire. Reliance is placed on those attending the unit to disclose if they are currently have social work involvement or are subject to child protection measures. **(Recommendation 9.4)**

1.21 There is no frequent attender policy in place within the Yate MIU. Taking action and investigating attendances is therefore solely reliant upon professional curiosity or judgement. The lack of a policy and standardised process means that a concerning pattern of attendances and the opportunity to explore these may be missed. A frequent attender policy is, we were informed, under development. **(Recommendation 9.5)**

1.22 Specialist midwives are in post to support midwifery colleagues with complex cases and we saw good evidence of the specialist midwives role in both internal and multi-agency liaison. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care. However, in adult substance misuse, when the specialist mental health midwife is on annual leave then liaison between the two services is not reliable. One pregnant woman was admitted to the midwifery unit and prescribed methadone at a different dose to that which was being provided by the substance misuse team. Staff told us that the midwifery team had not liaised with the substance misuse practitioner who advised us that they had to 'chase' midwifery for information pertaining to their client. **(Recommendation 1.3)**

1.23 Women are encouraged to book their pregnancy between eight and 12 weeks gestation. Community midwives conduct all booking appointments and in the cases seen 'request for help' forms and 'early help forms' were consistently used to alert and update the safeguarding team and specialist midwives of additional needs or vulnerabilities. All forms are triaged by the safeguarding maternity team to ensure appropriate actions as highlighted are taken.

1.24 Specialist midwives are flexible and proactive in engaging women with their services and we saw evidence of them having good oversight of cases held. Care pathways are in place for teenage pregnancies and substance misuse services. The perinatal mental health post is new and the pathway and service are currently being further developed.

1.25 We were informed that liaison between midwifery and other health professionals such as gynaecology and the pregnancy advisory service was effective. One area for development however, is liaison with ED departments who we were advised do not routinely inform maternity services if a pregnant woman attends having undertaken risk taking behaviours. This is a missed opportunity to share vital information which may assist midwives in ongoing risk assessments of vulnerable women and unborn children. **(Recommendation 3.1)**

1.26 We were further advised in midwifery services that although health visitors are informed of all bookings, it is not routine practice for community midwives and health visitors to meet regularly to discuss caseloads or conduct joint visits. This is a missed opportunity to share information and work collaboratively to ensure potentially vulnerable families are not overlooked. **(Recommendation 1.4) A letter will also be sent to Public Health informing them of this issue.**

1.27 It is not routine practice for midwives to see women at home ante-natally and this is only offered if concerns are identified. Routinely seeing women in their own surroundings enables midwives to assess a home environment and helps inform a robust risk assessment, either as a sole agency visit or jointly with health visitors or other specialist practitioners. (**Recommendation 1.5**)

1.28 Pregnant women are not routinely offered the chance to be seen alone by staff members at any stage in their pregnancy to discuss possible domestic violence issues. In cases examined, we could not be satisfied that questions around domestic violence were consistently asked as it was not routinely recorded. There was only space for one entry regarding domestic violence to be recorded in the maternal notes rather than throughout pregnancy as suggested by the Royal College of Midwives. Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy but it is unclear in the cases seen whether staff are identifying women who are experiencing domestic violence and referring them to appropriate support services. (**Recommendation 1.6**)

1.29 Police notifications of domestic violence incidents were seen within notes sampled in midwifery and we were advised that maternity services routinely receive all police reports where women are pregnant or have recently given birth. We were told that midwifery is represented at the multi-agency risk assessment conference (MARAC) meetings and MARAC information is recorded within patient maternity records.

1.30 Discharge information within the maternal hand held notes in midwifery services was lacking in cases examined. Although there are processes in place, including emails and phone calls to community midwives, in cases where safeguarding issues have been identified the system is incomplete in the way it is recorded. (**Recommendation 1.7**)

1.31 All cases seen in health visiting had a completed 'family needs health assessment' on file. This is a comprehensive assessment tool to identify children and families who may require additional support and thus ensure they receive an individualised service which meets their needs.

All assessments seen include analysis and action planning sections which were regularly updated. Action plans in the newer versions of the paperwork examined related to the analysis and goals documented, and were specific, measurable, attainable, relevant and timely (SMART).

1.32 The family nurse partnership (FNP) is a voluntary home visiting programme for first time young mums (and dads), aged 19 years or under. A specially trained family nurse visits the young family regularly, from the early stages of pregnancy until their child is two years old. The FNP team in South Gloucestershire consists of one supervisor and two family nurses. The maximum caseload size is 25 for each nurse but this is currently set to 23 to reflect the amount of travel involved to engage with these often mobile families. It also allows for some flexibility for staff to manage their caseload according to client requirements. Currently, 26% of teenage mothers are receiving FNP support. There is a waiting list for the service at present.

We met with a young couple who had engaged with the FNP with the goal to become better parents and to build their confidence as young parents. They were keen to tell us of their experience of the FNP:

*We heard how the young couple had been involved in setting their own goals at the outset of engagement with the FNP.*

*The main goal identified was that they both wanted to be better parents. The Mother described feeling that as teenage parents people might judge them and that there was a need to build their confidence to parent. They told us that at no time have they felt judged whilst they have been engaging with the FNP.*

*“You learn very quickly that with this programme that there is nothing to be scared of. We can talk about anything”.*

*The family told us that the nurse they work with is flexible and would see them in different locations as required and appropriate. These appointments would sometimes include wider family members including paternal grandparents and uncle and maternal grandparents.*

*Both parents talked about how they looked forward to their appointments with their nurse, the appointments being relaxed and friendly but also informative. The parents were given information and this has helped them to confidently make choices for their baby. They often refer back to their hand held file which contains various resources and sheets.*

*Whilst mum was pregnant the parents would read to their baby. Following the birth they have continued to read and share books with the baby which the child loves.*

*Both parents talked about their own aspirations and how they are starting to think about their future and they summarised the outcomes so far of their experience by saying:*

*“Without the FNP we wouldn’t have been as good parents as we are now.”*

1.33 There are recognised delays in child and adolescent mental health services (CAMHS) from the point of referral into the service to the point of therapeutic interventions being provided. This is further confirmed by the use of waiting lists according to assessed need. We saw however, that children and young people considered at risk could be assessed within 24 hours (urgent appointment) at the next available appointment (priority choice) or, where there was no immediate cause for concern the young person would be entered onto the standard waiting list for a 'choice' appointment. We examined files which demonstrated to us that children and young people can wait in excess of four months to receive an appointment following assessment. However, we did note that once 'in service' then young people in South Gloucestershire are supported well by CAMH practitioners. Where considered appropriate looked after children will receive priority treatment by CAMH professionals as their additional vulnerabilities are well recognised by practitioners. Guidance is also provided to GPs and children and young people in relation to other available support services in the interim waiting period.

1.34 In South Gloucestershire, young people have access to fully integrated sexual health services (contraception and sexual health (CaSH) in both generic and young people specific clinics provided in various different areas and locations around the County. Young people are therefore able to access sexual health and contraception advice at a time and in a location that suits their needs.

Emergency contraception is also available at all clinics, emergency departments and it can also be accessed seven days a week from designated pharmacies.

1.35 The current arrangement for risk assessing young people under age 18 in CaSH services is good. We examined evidence that demonstrated how consent is gained from all people aged 18 and under and that they are assessed as being Fraser competent at every contact thereafter. The current risk assessment includes questioning around domestic violence, female genital mutilation (FGM), self-harm and any concerns they may have regarding personal relationships.

The under-18 risk assessment is completed and reviewed at every new episode of care. Young people are also routinely asked whether they are known to other services, including children's social care. In records reviewed, details of names of social workers and Barnardo's against sexual exploitation (BASE) workers were clearly recorded. This demonstrates that practitioners are fully assessing potential vulnerabilities of young people at every contact. Collecting and recording this information also helps ensure that where necessary and required, professionals can be contacted to discuss any concerns in order to improve outcomes for young people.

1.36 Paper patient records are used within CaSH community settings; however, electronic patient records are used in clinics. We examined evidence that demonstrated how community records are scanned onto electronic patient records but only if vulnerabilities or risks have been identified. This means that health records for young people are not always complete and therefore do not form a holistic picture for the practitioner who may be seeing a young person in a different clinic, without a complete set of records. This also means that practitioners will also potentially not have access to all important sexual health related information about a young person, which is important to improve outcomes and services for them. **A letter will be sent to Public Health informing them of this issue.**

1.37 Due to issues around the provision of consent, partnership working between CaSH and school nursing services are inconsistent. We heard of a case where a CaSH practitioner had requested support from the school nursing service due to a young person failing to attend for a planned termination of pregnancy appointment. The school nurse was not able to offer the young person an appointment in school as the CaSH practitioner had not obtained consent from the young person to involve other professionals in their care. This is a missed opportunity to work in partnership to improve outcomes for young people. **A letter will be sent to Public Health informing them of this issue.**

1.38 There are currently no CaSH termination of pregnancy outreach nurses in South Gloucestershire. However, we are aware that integrated CaSH services have good links with the hospital trust. We were further informed there are good processes in place for young people who have been referred for a termination of pregnancy; for example all are followed up by the CaSH service. This was evidenced in files examined. This is good practice as it helps ensure that early help and prevention work can be carried out with the young person.

1.39 Outreach sexual health services are provided by Brook advisory services who are commissioned to provide weekly sexual health drop-ins in four secondary schools. A one-to-one outreach service for the most vulnerable young people is offered by a Brook nurse and a youth adviser who offer both clinical and risk/management behaviour change support on a one-to-one basis. Young people are able to influence where they are seen for their health review and whether they wish to be seen alone or with their carers. This helps young people to have choice and to more effectively engage with the process and take responsibility for their health care.

1.40 School nurse services are currently commissioned to deliver the 'healthy child programme' to five to 16 year old children and young people in South Gloucestershire. The service is also offered to those 16 -19 year olds at 6th forms attached to schools and those attending special schools. There are link school nurses for pupil referral units. However, there is a gap for those 16 to 19 year olds attending colleges or other forms of training in South Gloucestershire. **A letter will be sent to public health informing them of this issue.**



1.41 School nurse services are commissioned by NHS England to deliver vaccination programmes to identified populations. This includes the human papilloma virus (HPV) and meningitis (ACWY). This is delivered jointly by the core five to 19 year old workforce and bank staff.

1.42 A 'school health nursing assessment tool' has been developed, reviewed and is now awaiting final sign off. The tool is holistic and can be used as a single assessment framework (SAF) which is recognised across agencies. It encourages evaluation to be undertaken by the parent, carer and child or young person. In addition to this assessment process, visual assessment tools may also be used to aid hearing the child's voice. One tool examined included the questions; "my favourite toy is", "I feel sad when" and "three things that bug me". This is seen as a very child friendly method of obtaining important information.

1.43 School nurse drop in services are delivered in most secondary schools where commissioning arrangements are in place across South Gloucestershire.

1.44 Drop in documentation used in school nursing (currently in draft format) contains a risk assessment tool for mental health. However, there is no evidence of a child sexual exploitation (CSE) risk assessment process or pathway being available. The documentation contains a mental health risk assessment clearly stating the level of service offer and intervention required. In addition a safety plan can be developed with the young person. This is good practice. The document contains a Fraser and Bichard checklist but the assessment prompts do not guide the practitioner to robustly consider or exclude any risk of child sexual exploitation. **A letter will be sent to public health informing them of this issue.**

1.45 Awareness of safeguarding and child protection within GP practices visited was good. Regular 'vulnerable children' meetings between GPs, health visitors and in one case nurse practitioners were held in both practices visited. However, as school nurses do not participate in these meetings, information sharing in relation to school age children is weak. **(Recommendation 7.4) A letter will also be sent to Public Health informing them of this issue.**

1.46 Consideration of vulnerable children and young people feature high within adult substance misuse services in South Gloucestershire. In cases examined we saw that case workers consistently assess risk to this often hidden cohort of young people to whom adult substance users have responsibility or access. Where an adults personal circumstances change then questions are asked of them about any children and young people to whom they might now have access. This is good practice.

1.47 One GP advised that although the practice no longer has any direct contact with midwives, GPs are routinely informed of all women who book with maternity services and are asked to share relevant medical and social issues.

1.48 Both GPs visited stated that all ED and MIU attendance summaries received are seen by a single practitioner within the practice, but neither could provide reassurance that concerning patterns of multiple attendances would be identified or acted upon if the treating practitioner in the ED or MIU had not documented any concerns. There is the potential that a child or young person could be accessing multiple settings which, if looked at singularly, would not raise any alarm but as a whole may be less reassuring. (**Recommendation 5.1**)

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## 2. Children in need

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2.1 We saw that ED practitioners at BRHC liaised well with children's social care to share information and concerns. This includes sharing information with GPs and public health nurses. This is good practice and demonstrates that professionals are working together to safeguard children.

2.2 Children and young people in acute mental health crises can be accommodated in a young person's 'section 136' bed on the Southmead hospital site. The bed is contained within a four bedded specialist section 136 unit provided by the Avon and Wiltshire Partnership Trust (AWPT). Limited arrangements are in place to safeguard a young person who is admitted so that they are not exposed to any adult who is also being cared for in the unit at the same time. However, as part of these arrangements the young person is not able to access any outside space, including the unit's garden area. This was confirmed by managers who told us that this can be for up to 72 hours whilst a place of safety is found for the young person.

From documentation examined, we are not assured that the unit places sufficient priority in meeting the needs of a vulnerable child or young person accommodated there. Adult mental health staff working in the unit do not have the appropriate competencies in the assessment and management of children aged 16 and under. The multi-agency operating protocol in place is that agency staff with the appropriate competencies are employed to provide care and supervision to the young person, whilst these are being sourced the police remain with the young person. We were not made aware of any safeguarding arrangements, including the trust's safeguarding team, being made aware that a child had been admitted to the facility. We were further advised that the bed had recently been occupied by a twelve year old child. (**Recommendation 8.2**)

2.3 All GPs, school nurses and health visitors receive a copy of the discharge summary for all children and young people who attend the children's ED at BRHC. This provides sufficient information about the reason for the attendance and any subsequent treatment or action that may be required by other professionals. Discharge summaries for those children or young people who do not wait for treatment were not being generated by the Med-way IT system which is used in the department. However, this has been acknowledged by the trust and subsequently changes have been made to ensure that all attendances, including those who did not wait for treatment, generate a GP letter. This means that GPs are better informed and in a position to be able to consider the full details of the ED attendance in the context of the child or young person's overall health needs.

2.4 Children and young people who attend ED at Southmead hospital following self-harm, overdose or other risk taking behaviours are safeguarded well. Their mental health is triaged using a mental health matrix which assesses their risk. During normal working hours, and if there is low risk, the young person can be discharged home with a CAMHS appointment for the next day. Where a child is under 16 and considered medium to high risk and requires admission, they are transferred to BRHC for overnight observation as recommended in NICE guidance. However, if a young person is aged between 16 and 18 and requires a period of overnight admission and observation they are admitted to the Southmead hospital ED assessment unit until they are reviewed by CAMHS the following day. Out of hours, the ED team have access to on-call CAMH psychiatry practitioner where more specialist advice can be provided as needed, for example where a specialist in patient facility is likely to be required.

2.5 At BRHC we heard that young people's mental health needs are being appropriately triaged using a mental health 'traffic light matrix' which enables practitioners to assess the risk level of children and young people in a mental health crisis. During 'out of hours', most children and young people will be admitted to the children's assessment unit whilst they wait for a CAMHS assessment which routinely takes place the following morning. Therefore, those children and young people with low-medium risk are not being kept in the hospital inappropriately. We were informed that children and young people who are admitted as medical patients requiring a CAMHS assessment can often wait for several weeks until they are physically well enough for that CAMHS assessment to take place. This includes those children who are waiting for tier four urgent care beds. However, once they are considered fit enough for an assessment to take place then it is completed as soon as possible.

Although an annual risk assessment is carried out on all wards, at the time of our inspection we were not assured that these children and young people were benefiting from a more formal risk assessment being carried out, either to assess the risk that they pose to themselves or to others in the environment in which they are being cared for. The current process need to be reviewed to ensure that all children and young people who are admitted for CAMHS assessment are better safeguarded. (**Recommendation 2.3**)

2.6 When ED practitioners at BRHC have any safeguarding concerns we saw that they are completing children's social care referral forms, which prompts them to provide as much information as possible regarding the reason for the referral being made. ED practitioners are aware of the process of how to make referrals to children's social care if they have any concerns about the safety of children or young people. We were informed that initial concerns are always raised by telephone, which is then followed-up in writing within the agreed timescales. All completed referral forms seen provided situational analysis and articulated risk well. Outcomes following referrals are documented within the ED patient records.

2.7 All looked after children who attend the children's ED at BRHC are routinely referred to children's social care to share information regarding the attendance. This means that children's social care has access to important information relating to looked after children's health needs.

2.8 There is no safeguarding alert or flagging system on the electronic system in use at Yate MIU and no facility for staff to flag records manually. Although we saw that staff do ask attendees if a social worker is or has been involved with a child or family, they are reliant on information being shared voluntarily by parents, carers or young people. The new national CP-IS IT system, once in place, will resolve this issue but meanwhile staff are potentially unaware of essential information about a child's status which would aid their assessment of risk. (**Recommendation 9.6**)

2.9 We were told that MIU staff have good access to CAMHS staff for advice if required. There is a deliberate self-harm risk assessment tool to aid decision making during triage and an emergency pathway is in place should a child or young person attend in mental health crisis. We were told that there are plans for CAMHS to conduct mental health awareness training sessions for MIU staff although at present staff members told us they have received no such formal training.

2.10 There was no flagging or alert system in use on case files of vulnerable children within health visiting. In school nursing for example, those children and young people with safeguarding records are differentiated by a yellow folder. Relevant information could be found within the health visiting records and the safeguarding supervisors separately held lists of all children subject to child in need or child protection plans. However, a robust method of flagging vulnerable children's case notes would ensure that practitioners are immediately aware of those classed as most at risk. ***A letter will be sent to Public Health informing them of this issue.***

2.11 In the family nurse partnership, genograms were seen in use in all sampled records along with chronologies of significant event sheets. Evidence of safeguarding supervision was seen to be recorded in client notes and reports and referrals to inform child protection meetings reveal detailed assessment of need, identification of concerns and analysis of risk. The voice of the child was consistently demonstrated and considered in all cases examined.

2.12 South Gloucestershire CAMHS have a pathway between their own services and adult mental health services with specific arrangements also in place to provide support to young people aged between 17 and 18 years. This protocol ensures young adults are not missed when a referral is made to CAMHS just before their 18th birthday and will be duly considered for care and support with both adult and adolescent services working together to support those people.

2.13 In CaSH services, all referrals to children's social care go via the safeguarding named nurse team so that referrals can be tracked and followed up by them as required. Practitioners are individually notified and provided feedback if the quality of referrals is not of a high standard. We were informed that practitioners are informed directly of the outcomes of a referral and a copy of this is filed within client records.

2.14 Although we examined evidence that risk assessments are being completed for all young people aged 18 and under in CaSH services, practitioners need to ensure that if vulnerabilities are identified then these are explored in more detail as it may help inform the care plan for young person. In one case examined for example, a young person was identified as feeling depressed. However, this was not documented as being explored any further, the reasons for their feeling this way or any additional support that might be required were not recorded in the same place in the records. **A letter will be sent to public health informing them of this issue.**

2.15 Adult mental health records examined demonstrated good work by practitioners in working closely with clients to build relationships of trust and thus better protect potentially vulnerable young people.

*In one case examined in adult mental health we saw how a caseworker took on a client who had previously been diagnosed as bi-polar and whose child was subject to child protection measures. The mother had received care and support from the New Horizon mother and baby unit and following this the child protection measures were reduced to child in need.*

*The mother was considered by social care to be difficult to engage with and resistant to intervention following her discharge from New Horizon and as a result child protection measures were again instigated.*

*Over time the adult mental health case worker developed a good working relationship with the mother who began to explain her feelings of isolation and mistrust of services involved and how she felt the way she expressed herself had been misinterpreted. The case worker attended all child protection meetings and core groups and a diagnosis review was undertaken where it was considered that the original diagnosis of bi-polar could not be affirmed.*

*Through continued close working the child was removed from child protection measures and close bonds between mother and child have continued to grow.*

2.16 GPs expressed frustration in accessing CAMHS for young people. It is perceived by those GPs we spoke with that unless a patient is in acute mental crisis CAMHS will not accept referrals and that there is little else available within the community to support children and young people. We were later advised however, that GPs are kept informed and up-to-date of support networks available for them to signpost young people into when CAMHS do not accept referrals made to them and further that 'off the record,' a free and confidential mental health support network for young people aged between 11 and 25, are commissioned by the CCG to provide counselling services when the CAMHS threshold is not met.

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### 3. Child protection

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3.1 Southmead hospital ED practitioners routinely refer cases to children's social care where there are concerns or where social worker involvement has been identified within the family. Electronic alerts on the patient record system notifies practitioners where a child has a child protection plan or if they are looked after. Copies of all referrals are sent to the trust's safeguarding team and these are monitored for quality and outcomes. However, referrals examined were often incomplete and did not provide any analysis or clear articulation of risk. (**Recommendation 1.8**)

3.2 Children and young people who accompany their parents to the ED at Southmead hospital benefit from good arrangements to keep them safe and limit their exposure to adults who are being treated in the department.

3.3 We saw that ED practitioners at BRHC liaised well with children's social care to share information and concerns; this includes sharing information with GPs and public health nurses. This is good practice as it demonstrates that professionals are working together to safeguard children. Where ED practitioners at BRHC have concerns regarding the safety of children and young people, they are being appropriately discussed at 'cause for concern meetings' and information is being shared in a timely manner with children's social care.

3.4 Those children and young people who are transferred from Southmead hospital to BRHC and then do not attend for planned, pre-arranged appointments are being followed up appropriately. We were informed that once the referral comes into the hospital it is logged on the med-way IT system and therefore if any children or young people do not then attend for appointment they can be followed-up via the University Hospitals Bristol NHS Trust (UHBNHST) did not attend policy. We heard that there have been concerns raised with following-up young people aged 16 to 18, as this age group falls outside of the children's hospital's remit. However, following audits undertaken, UHBNHST has made improvements and we were informed that there is now more ownership of the policy across the hospital.

3.5 Children and young people attending the dedicated children's ED at BRHC are benefiting from good assessment of any safeguarding and child protection concerns. The med-way IT system flags ED record to highlight all children and young people who are looked after, have safeguarding concerns or have a child protection plan, including those children who have previously been subject of a child protection plan in the last two to three years. We also heard that additional flags have been put on to ED records to alert practitioners of concerns, in particular relating to fabricated induced illness. This means that practitioners are being alerted well of the need to consider any additional vulnerability which will in turn help ensure that their assessment of children and young people is robust.

3.6 We were told that if a child or young person is referred to an ED from Yate MIU then staff will speak directly to an ED consultant or paediatric consultant as appropriate. The ED and MIU then liaise to ensure the child or young person arrives safely. If the referral was due to safeguarding concerns 'First Point would routinely be contacted.' First Point is a single point of access to children's preventative, social care, and specialist services and they would also be contacted in the case of non-attendance at the ED.

3.7 The safeguarding team and specialist midwives provide high levels of support to midwives and the women in their care. To ensure midwifery representation they will, if considered appropriate and necessary, attend initial child protection conferences, core groups and pre-discharge planning meetings. We saw good evidence of attendance at those meetings and that outcomes are appropriately disseminated to make sure the wider team is fully aware of the most up to date information and plan.

3.8 We examined referrals made to children's social care from midwifery services and saw that they shared important information, clearly analysed and articulated risk, the potential impact of parenting behaviour on a new born child and what the expected outcome of the referral was.

3.9 Safeguarding information is held within hospital notes in midwifery services at Southmead hospital. The most up to date information and birth plan is bright yellow which is easily identifiable within the notes and ensures easy access for staff to important information. An alert system called the 'red bubble' is utilised on the Euroking IT patient record system, which holds a summary of the safeguarding information within the medical notes.

3.10 Safeguarding birth plans, which are jointly prepared by the social worker, midwife and other relevant professionals, were found within all relevant cases sampled in midwifery services at Southmead hospital. These plans are also shared with the woman concerned which is good practice. We also saw that alerts are placed on the Euroking IT patient record system and that community midwives hold a chronology of cases securely within their bases. These measures all ensure that staff are alerted to cases of concern and have access to up to date information and plans.

3.11 The New Horizon mother and baby unit at Southmead hospital offers a four bed specialist service for women suffering from mental illness in the peri-natal period, particularly when there are issues relating to attachment and when the mother's mental illness has an impact on her ability to care for her baby. The team will also assess and offer advice and liaison for women ante-natally. We saw that health professionals working within the unit prioritise attendance at both initial child protection meetings and core groups. We further noted that nursery nurses are also encouraged to report into these meetings to act as the voice of the child. This is good practice. However, in cases examined we saw that decisions made at child protection meetings do not always go on to inform the care planning process. In one case examined we saw that where it was decided, in agreement with the mother, that she should not be allowed to leave the unit with her child for more than half an hour at a time this was not clearly recorded in the patient record or plan of care. Reliance was placed rather on staff handover to share such information.

We spoke with the mother who told us that she agreed with the restrictions placed on her (she was a voluntarily in-patient) but her record did not contain a signed copy of her agreement, the restrictions were not clearly written into her care plan and there was no evidence of the voluntary agreement being reviewed on a regular basis. This case did, however, show how intensive work by health practitioners with the mother had resulted in her developing excellent bonds with her child where previously the two might have been separated. (**Recommendation 6.1**)

3.12 Health professionals working in the New Horizon mother and baby unit told us they have very good working relationships with multi-agency professionals. Social care workers liaise closely with them often visiting mothers on the unit to discuss cases with them and share information accordingly. Close links are also quoted with community based mental health teams where joint visits will be undertaken where possible prior to admission to the unit.

3.13 In health visiting we saw that where appropriate, minutes of child protection or child in need meetings and plans were held within client case notes. We were advised that practitioners actively 'chase' these if they are not received in a timely way.

We also saw evidence in case records of multi-agency collaboration to ensure children were kept safe. We saw appropriate sharing of information about unresolved or increasing needs to aid assessment of risk across agencies. Referrals to children's social care via 'first point' seen within case notes were comprehensive, analytical, articulated risk and also the expected outcome of the referral being made.

3.14 Overall, the single assessment framework forms which had been completed by health visitors we examined were child focused and resolution focused. We saw a case where an effective single assessment framework (SAF) had a positive impact on a child not meeting the thresholds for children's services involvement.



3.15 One case examined in health visiting demonstrated how the health visitor followed NBNHST policy regarding bruising to a non-mobile baby and appropriately reported this to the on call paediatrician. The entries recorded by the health visitor reflect that she was being asked by the paediatrician to make a judgement about the consistency of the injury with the history given. This was an inappropriate request that challenges professional boundaries and does not reflect the course of action that should be taken as per LSCB policy. We were assured by the safeguarding team that the named doctor had been informed of this and was making further enquiries.

*The health visitor in this case was seen to be swift in responding to a chance contact from the non-mobile child's mother who reported that her child had a bruise on their head. The mother stated that she had tripped and fallen in the early hours banging her elbow on the baby's head. The health visitor invited the mother and baby to be seen that afternoon for review.*

*During the review the health visitor undressed and examined the baby. The bruise was reported to be visible on the baby's head as the mother had explained. In response to this the health visitor contacted the on-call paediatrician as per NBNHST policy. The Doctor asked the health visitor if the history and findings 'seemed credible' and if the bruise matched the mechanism of injury as described by Mother. The health visitor recorded in her records that she did not feel she could say if the injury exactly matched the circumstances as described.*

*The outcome of the discussion was that the paediatrician stated that they did not feel the baby needed to be seen and it was agreed that the health visitor would arrange for the baby to see their GP to assess the baby. The baby was assessed by the GP later that day and found no medical concerns regarding the head injury but did note that an older child also present had bruising and scratches. The health visitor advised the GP to speak to the social worker to share this information.*

*Safeguarding supervision was provided to the health visitor and the record seen revealed an active plan that was awaiting updates from the social worker. Further analysis of the record also revealed that mutual information sharing between with the health visitor and the GP was good. It was not clear though if information had been shared with the school nurse following concerns raised by the general practitioner for the school aged child also seen that day.*

3.16 School nurses do not maintain effective oversight of domestic abuse incidents. Notifications of domestic violence are reported to be sent to schools and to the safeguarding team. The safeguarding team advise school nurses of significant domestic violence incidents. In one case tracked the school nurse was seen to be concerned about a child who may have additional needs due to the impact of parental mental health following an ED attendance in crisis. The school had not informed the nurse of any domestic violence incidents and it was only when the school nurse opportunistically enquired about any concerns that the information was shared about domestic incidents in the home. There is no benchmarked process in place around liaison between schools sharing the information about domestic abuse incidents with school nurses. ***A letter will be sent to Public Health informing them of this issue.***

3.17 We were told the paediatrician attends strategy meetings and will feedback the outcome and any actions to the school nurse. School nurses receive invites to child protection case conferences and will submit reports accordingly. This is prioritised over other areas of work. School nurses offer health assessments as an outcome at case conferences but if there is no identified role for the school nurse they will withdraw and not be part of the core group unless a health concern is later identified. We were told that school nurses participate in child in need meetings and that conference minutes are received in a timely manner.

3.18 In CAMHS, requests for attendance at initial child protection conferences are sent to community paediatricians who will then review the case and attend the meetings if considered appropriate to do so. Community paediatricians provide reports to all case conferences where they have provided a service to the child. However, in records examined we did not evidence this further. We were further informed that CAMH practitioners are not routinely invited to attend conference even if they are providing care and support to the child or young person concerned. There is a missed opportunity for practitioners to attend these important initial child protection conferences where information is shared which might better inform them in their work with vulnerable young people. By not routinely providing written reports to inform conference there is also the risk that impactive decisions are made without those concerned having access to all available information. ***(Recommendation 7.1)***

3.19 In CaSH services, all children aged 13 and under seen in clinic are referred to consultants for an assessment and there is a consultant on-call for young people seen in the community sexual health services. We were informed that all children aged 13 and under are routinely referred to children's social care and CaSH workers are highlighting vulnerable young people to appropriate services in a timely manner.

3.20 We examined evidence that clearly demonstrated to us that safeguarding children plays a large part of the adult substance misuse keyworker relationships with their clients, with significant effort being put into a continued assessment of risk to children and young people. We examined cases which demonstrated that staff were aware of how to escalate referrals to children's social care where they considered that risks presented to them had not been appropriately considered and did so after consultation with peers, senior managers and the trusts safeguarding team. Client relationships with children were also considered and recorded, such as how they interacted with their child during consultations. The 'think family' approach is well embedded in this service.

3.21 Where child protection measures were in place we saw that adult substance misuse practitioners included this in all intervention plans with adult's clients. 'Flags' on the client record IT system alerts practitioners of any child protection measure in place and the risk assessment process also takes into account vulnerable children and young people and is open to continued review.

3.22 The 'think family' approach is well embedded in adult mental health with practitioners well aware of the importance of identifying and considering the needs of children and young people in the care of adults with enduring mental health problems. This is good practice and we examined evidence of due consideration being given to the emotional wellbeing of young people who, in one particular case examined, had shared caring responsibilities for their parent. Support strategies had been considered and put in place to assist the young person's understanding of their parents mental health problems.

3.23 Adult mental health practitioners routinely develop indicators of mental health relapse and crisis intervention plans with their clients which are, with consent, shared with others including social care, family members, midwifery and health visitors to better inform them of how to both recognise relapse and what action to then take. These include actions to protect vulnerable children and young people.

3.24 We spoke with practitioners in adult mental health who advised us that they are routinely invited to take part in both pre and post birth planning meetings with midwifery services when they pertained to any of their clients. This is good practice and ensures plans are available and understood by all involved parties to protect unborn and new born babies.

3.25 Where child protection measures were in place we saw that adult mental health practitioners included this in all intervention plans with adults concerned. The risk assessment process also took into account vulnerable children and young people. However, we could not be satisfied that all risk assessments are regularly reviewed and updated, especially when an adult service users circumstances change. Although detail was often contained within the contact diary notes of practitioner/client contact the actual risk assessments did not clearly articulate continued review. (**Recommendation 8.1**)

3.26 GPs we spoke to were confident in how to refer a child or family to children's social care via 'first point' and copies of referrals were copied into patient records. GP practices visited had appropriate processes in place to ensure that requests for reports for child protection conferences were responded to. Conference minutes, plans etc. when received, are also scanned onto patient records.

3.27 GP practices are using electronic flagging systems to identify vulnerability, looked after status and child protection issues on the EMIS patient record system which is used by all practices within the county.

However, there is no systematic way to notify primary care of children who are looked after, subject to child protection or child in need plans. GPs told us that they rely on information shared by health visitors (children aged five years and under only) and also use receipt of any relevant paperwork such as requests for information for child protection conferences as an indicator to flag a record. This is not a robust system to ensure GPs are fully aware of the status of vulnerable children registered at their practices. (**Recommendation 4.1**)

3.28 The named GP strongly promotes attendance at child protection conferences where possible as the value of multi-agency working and sharing of expert knowledge is widely accepted.

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## 4. Looked after children

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4.1 Children and young people continue to benefit from ongoing, timely health reviews in South Gloucestershire. The designated nurse for looked after children has a system of recording and planning when reviews are due. Reviews seen clearly demonstrated the child's health journey, with each review enhancing and contributing effectively to the overall improvement of the child's health. This was particularly evident in the reviews for children under five where reports were written to the highest of standards for potential fostering and adoption.

Older children and young people benefit from conversations and assessment of risk taking behaviours as part of their review. Referrals are routinely made to local sexual health and substance misuse services where need is identified.

4.2 Children and young people who are looked after by South Gloucestershire local authority benefit from comprehensive, child centred initial health assessments and health reviews. The designated doctor for children looked after carries out the majority of initial health assessments and all health reviews for children under five. Health reviews for children over five are carried out by the designated nurse for looked after children.

4.3 A well-established process is in place to ensure timely notification of a child entering into care and a clinic appointment is offered to see the child for their initial health assessment. Professionals involved with the child are contacted and asked to provide any health information that they have so that the assessment is as comprehensive as possible. This includes GPs, health visitors and school nurses. Good efforts are made to obtain parental health histories and even when these are not available for the initial health assessment, the child's health details are updated as and when they become available. This is good practice as young people leaving care tell us that parental health information is important to them as they enter into adulthood and engage with adult services.

4.4 Older children and young people who do not want to engage with the initial health assessment are actively followed up by both designated professionals. In a few isolated cases, the designated nurse will meet with the young person to carry out an initial health assessment and share this information with the designated doctor who retains responsibility. This proactive approach means that the majority of young people looked after in South Gloucestershire benefit from a comprehensive and meaningful initial health assessment of their needs.

4.5 Good use is being made of carer's assessments to inform initial health assessments and health reviews. These assessments ask carers to comment on the child or young person in their care's emotional and physical health, and we saw evidence of sensitive and thoughtful contributions by foster carers to the health assessment and review process.

4.6 Young people who have engaged in the initial health assessment process receive a personalised letter from the designated doctor which summarises the content of the assessment. The letter is young person friendly and does not contain medical jargon; instead it helps to focus and engage the young person in their healthcare. This is some of the best practice seen by inspectors during the CLAS review programme and is to be applauded.

4.7 We saw good and effective use of completed strength and difficulties questionnaires (SDQs) to inform health reviews. We saw how completed SDQs were scored and where concerns are identified these were discussed as part of the review and communicated to emotional health and wellbeing teams.

4.8 The looked after children team are routinely writing letters to GPs to ask them to contribute to initial health assessments. We examined evidence which demonstrated that GPs are contributing and this is good practice as it helps inform the overall Initial health assessment and resultant care plans for looked after children.

4.9 Most children and young people who are placed out of South Gloucestershire area will be seen for health review by the designated nurse for children looked after. For those children that she is unable to visit because they are placed more than 50 miles away, their reviews are quality assured using the national audit tool.

4.10 Health passports provided to care leavers have only recently been introduced to support and provide them with a summary record of their health. We did not see any evidence of health passports in files examined although we were shown blank copies and discussed how groups of young people, service users and Barnardo's have been involved in the development of this important documentation.

4.11 In CaSH, a one-to-one outreach service for the most vulnerable young people, including looked after children is offered; a Brook nurse and youth adviser offer both clinical and risk/management behaviour change support. The designated nurse for looked after children is trained to provide relationships and sexual health advice and information. There is also a targeted youth support service within the looked after children team in children adults & health at South Gloucestershire council, within which the specialist youth workers are trained to talk to young people about healthy sexual relationships.

4.12 Children and young people looked after are able to effectively access support for their emotional health and wellbeing from a number of different commissioned services. These include 'thinking allowed', primary mental health workers and the 'children living away from birth family' (CLAB). There is also 'off the record' which is a local counselling service which young people can refer into. Where specialist CAMHS support is needed, then referrals into the service are fast tracked so that no child or young person looked after is waiting excessively to access the service.

4.13 CAMHS practitioners in the CLAB team provide support to young people in care who are placed out of area. Although South Gloucestershire practitioners will not always get to discuss with them or their local care providers in person due to distance, teleconference meetings are routinely held so that cases can be held locally for when the young person returns to South Gloucestershire.

4.14 GP records of looked after children contained copies of initial health assessments and health reviews. This is important as the GP is the primary record holder and they need to have a comprehensive record of all health needs. We were told that GPs are routinely asked to feed into IHA's and RHA's.

4.15 Children and young people from black or minority ethnic backgrounds, including unaccompanied asylum seekers, have their cultural and religious needs considered and met as a consequence of thoughtful and well informed initial and review health assessments. Looked after children nurses are routinely recording the ethnicity, language and religion of looked after children. This is important as the information can help ensure that the looked after child has access to culturally sensitive care as required and it can also inform how best health support can be delivered.

*In one case examined we saw how a 15 year old looked after child has been accommodated in the care system since early 2015. The young person was an unaccompanied asylum seeker from Afghanistan with no family or friends in the UK. English is not their first language and so the services of an interpreter have always been used.*

*The young person's Initial health assessment was seen to be completed within timescales with an interpreter present to assist the process and ensure all important information was captured.*

*We saw that the ethnicity and religious status recorded as part of the initial health assessment with good attention paid to cultural needs. The young person was provided with a prayer mat and cap and they have since been taken to a mosque by their foster carers to enable them to pray and spend time with people who speak the same language.*

*The voice of the young person was clearly evident within the initial health assessment reviewed, even to the point of recognising the importance of halal meat in their diet. We also saw that there was continued good liaison between professionals involved in the case.*

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## Management

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

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### 5.1 Leadership and management

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5.1.1 Ethnicity is not routinely being recorded in the ED notes at Southmead hospital. It is important that this basic information is obtained so that a holistic picture of the child or young person's background can be used to inform the way that care and support is provided. (**Recommendation 1.9**)

5.1.2 The current journey that all under 16 year olds have to go through to reach the ED at BRHC is complex and the signage was also seen to be confusing. Due to this, lone parents that may be accompanying children in distress do not currently have rapid and easy access to the department during emergency situations. The trust recognises these limitations and the difficulty that some parents may experience when trying to reach the department, and as such there are plans to improve the child's and parent's journey. However, we could not be assured at the time of inspection that that this will avoid confusion and improve the access to the department in the near future. (**Recommendation 2.4**)

5.1.3 We were advised that Yate MIU has access to an on call paediatric consultant for advice if needed at all times. Three of the units emergency nurse practitioners (ENP) are paediatric trained nurses and all clinical staff have had additional training in advanced life support for children. We were told the MIU rely on agency nurses to cover staff non-availability. An audit at the MIU reported to have revealed agency staff needed to improve their standard of practice around safeguarding children. Staff told us they have highlighted this with the agencies and shared policies and procedures and this has reportedly raised the standard of their practice. However, steps to ensure that staff working in the unit are trained to the standard outlined in the intercollegiate document are required. There needs to be a clear understanding of the roles, responsibilities and accountabilities of both trained and untrained staff undertaking clinical roles and making associated decisions. **(Recommendation 9.7)**

5.1.4 There is no administration support to the safeguarding team within midwifery services who advise they currently spend approximately 25% of their time on administration duties. We were advised that the role of the specialist midwife for teenage pregnancies is currently under review. This post is reportedly valued by the client group it serves and anecdotally has a positive impact on the education and lifestyle choices of this vulnerable group, although no formal evaluation has been undertaken to formally assess its effectiveness. The team were nominated by their peer group for Team of the Year 2015 which demonstrates how valuable colleagues feel their work is. **(Recommendation 1.10 and Recommendation 1.11)**

5.1.5 In CAMHS there is an escalation policy in place that all health practitioners are made aware of. We were further advised that it is not used very often due to good working relationships between health and children's social care, but it is used more regularly in relation to referrals into the domestic violence MARAC. Cases referred to the CSE MARAC are also audited annually. Cases are dip sampled to check the quality of work undertaken and if required improvements are made to ensure best practice. For example, one audit highlighted that health practitioners were identifying CSE well but they were not necessarily using the CSE referral tool well. Staff training in the use of the specific referral tool was provided and we were now assured that all referrals to the CSE MARAC were accompanied by a completed referral tool.

5.1.6 Files examined in CAMHS were sometimes difficult to navigate, included multiple duplication of documentation, did not include clear and detailed plans of care and the quality of risk assessments was often poor. We are however aware that this was subject to recent CQC recommendations and work is ongoing to improve the quality of client records.

5.1.7 The arrangements for the role of designated nurse and named nurse for looked after children do not reflect Working Together or intercollegiate guidance. Both posts are covered by one single person, whose job description has not been revisited for several years despite significant re-organisation locally and nationally. There is no administrative capacity identified to support the role and this is not sustainable. **(Recommendation 7.2)**



5.1.8 A chronology or 'family life events form' is held in the front of client case notes used by health visitors and these are easily accessible. Completion of an up to date chronology is good practice and provides ease of access to significant information contained in the paper files, particularly in complex cases.

5.1.9 Referrals into the school nursing service follow a flow diagram process. Referrals are triaged to identify level of urgency and the appropriateness of the referral with actions taken to signpost to other services whilst urgent referrals are offered an appointment. Non-urgent cases are placed on a waiting list with variable waits between eight and 18 weeks for an initial school nurse assessment. We are aware that currently 85.6% of referrals were seen within eight weeks.

One case sampled revealed that a child was referred to the school nurse team and waited 12 weeks for their initial assessment. However, once the assessment had been undertaken the child was referred to the community paediatrician, orthoptist and occupational therapist.

5.1.10 Challenges in staff capacity for non-urgent referrals to the school nursing team are leading to delays for children and young people in having their needs assessed and any ongoing referrals to other services. ***A letter will be sent to Public Health informing them of this issue***

5.1.11 In cases examined we saw that there is some variation in the standard of record keeping in within school nurse services. For example, chronologies used did not consistently reflect the significant life events for the child. Some cases revealed that health visitors are not transferring immunisation status across on transition to school nursing. We were told that for universal cases school nurses would not have the capacity to take any action regarding this. ***A letter will be sent to Public Health informing them of this issue***

5.1.12 In one school nurse case sampled we saw that there was no summary from the health visiting service at transition and in another case a child protection report had some evidence of the child's voice and analysis of risk but lacked the underpinning assessment and rationale for decisions taken. Closer audit of case files would highlight these discrepancies. ***A letter will be sent to Public Health informing them of this issue***

5.1.13 Cases held within CAMHS are often subject to test so as to measure the success of therapeutic interventions and reduce the risk of 'drift'. Individual session outcome monitoring takes place alongside an examination of how an individual client feels in the context of their family during the course of receiving support from CAMH practitioners. This ensures that interventions remain focussed according to need.

5.1.14 The recently introduced 'CAMHS summary of risk of concerns assessment tool' which is yellow in colour and kept at the front of client paper records, gives practitioners an opportunity to clearly record current risk factors, including the current risk to self, to others, from others and any relevant social factors in the case. It also includes an opportunity for practitioners to complete a 'safety plan'. This document would be further enhanced by the addition of a 'review by' date and the opportunity to re-assess risk should the young person's circumstances change.

5.1.15 There has been audit of cases referred for CAMH service assessment and intervention where they were declined. It was noted that all declined cases were followed up with a discharge letter being sent to the person making the referral informing them of the reasons for the young person not being accepted and what other therapeutic interventions might be suitable. This is backed up by the provision of a 'where to get help' booklet which provides information to children, young people and their families in the County. We examined examples of discharge letters sent to referrers and saw that they contained good information to explain the reason for no further CAMH interventions.

5.1.16 The pregnancy advisory service in CaSH carries out a rolling survey in order to improve their services for women and young people receiving care and support. There are comment cards in all clinics and a recently formed public patient group will help ensure that services are tailored to meet the population's needs.

5.1.17 South Gloucestershire specialist drug and alcohol services have a service agreement in place with social services that all invitations to attend initial child protection meetings and associated core groups will be attended by practitioners. One case examined demonstrated that when the nominated keyworker was unable to attend then the service manager attended in their absence. Key points discussed at the meeting were entered onto client electronic records along with the discussed plan of action. This is good practice as adult substance misuse workers hold important information pertaining to clients that is useful in informing child protection meetings and outcomes.

5.1.18 Adult mental health practitioners are aware of the escalation policy in relation to resolving disagreements with social care and how to invoke it through their line manager and through to the trust's safeguarding team as necessary.

5.1.19 In adult mental health invitations to attend core meetings were often received at short notice. Operational managers recognised this and, in discussion with partners, agreed that if the invitation was at short notice then rather than supply a poor report the meeting could go ahead as planned and a good quality report be submitted after the meeting had taken place but that important information that might inform the decision making process would be provided. This places an emphasis on good quality reports being submitted to inform conference at all times.

5.1.20 Operational managers in the adult mental health service have a clear expectation that mental health practitioners will be members of core group and attend child protection conferences; submitting written reports both if attending and if they are unable to attend.

We saw case examples of practitioners attending child protection conferences and contributing to the decision making process effectively. We were further advised that the quality of reports submitted to inform conference is audited to test their quality. We further noted that minutes from such meetings were scanned onto the RiO IT system and, where appropriate, went on to inform the care planning process.

5.1.21 The designated doctor for looked after children is also the medical advisor for fostering and adoption. Both the designated doctor and designated nurse for looked after children told us that they had access to appropriate supervision and support networks.

5.1.22 The designated professionals for looked after children have contributed to this year's joint strategic needs assessment and health needs planning with public health to identify the health needs of this vulnerable cohort of young people.

5.1.23 The designated professionals for looked after children are part of the corporate parenting board and the designated doctor chairs the sub group for looked after children's health. The health of looked after children is regularly reported to and monitored by the LSCB. A robust set of key performance indicators are used to monitor timeliness of assessments and reviews and any breaches are reported along with an explanation for the breach taking place.

5.1.24 NBNHST undertakes a looked after children annual report which outlines how the looked after children service is performing setting out objectives and priorities for the coming year. For the period 1<sup>st</sup> April 2014 to 31<sup>st</sup> March 2015 priorities include the implementation of the care leaver's passport. Care leavers we speak with tell us of the importance to them of full and comprehensive health information being provided to them on leaving care

5.1.25 Current service user engagement and participation in the development of children and young people's health services within CCHP is good with young people involved in the assessment and development of all children's services. This even includes young people being involved in the recruitment process for practitioners who plan to work in children's health, including the recruitment of senior practitioners. This relationship with children and young people is in some part enhanced by NBHT working in partnership with Barnardo's. Interim commissioning arrangements for 2016 to 2017 include a stipulation that this relationship should continue and post 2017 arrangements should include similar arrangements for young service user input but this does not specifically include a requirement to work directly with Barnardo's.

5.1.26 From September 2014 the Named GP has been supported by the children commissioning support manager from funding received from NHS England. The Named GP attends the main board meetings of the SGSCB and is a member of the quality assurance sub group. All GP practices in South Gloucestershire have identified a lead GP. The CCG named doctor facilitates three meetings a year to which all the GP safeguarding leads are invited, this provides a useful forum for peer review and complex case discussions.

5.1.27 The named GP chairs a quarterly safeguarding children lead GP meeting (minutes seen) which is well attended. This gives GPs a chance to discuss issues with peers and keep up to date with changing practice and then take this back to share with their practice staff. GPs we met with valued the support and guidance provided by the named GP

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## 5.2 Governance

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5.2.1 CAMHS IT systems are outdated, difficult to use and time consuming of practitioner resources. We were advised of difficulties in scanning important documents from paper files onto client records such as minutes from child protection conferences which might then be used to inform professional engagement with vulnerable young people. We were told that when printing PDF documents that printers would regularly 'jam' and stop printing. This would often result in sometimes confidential documents being printed later in the day when the original person requiring them was no longer in a position to collect them. Staff also told us of their frustration in trying to log onto systems, often spending in excess of 20 minutes in the logging on process alone. Printing prescriptions for clients was also routinely problematic which meant that prescriptions would then be hand written which is not in line with NICE guidelines. (**Recommendation 7.3**)

5.2.2 Information sharing in CAMHS can be a protracted process with documents being duplicated several times. We examined files which contained multiple duplicated documents making them more difficult to navigate. Most files seen were not well set out and did not clearly articulate identified risks, action plans and planned interactions or care planning with young people. However, where practitioner history sheets were up-to-date we did see that these were often used to indicate planned interventions. We are advised that case files within CAMHS are currently under review.

5.2.3 CAMHS have recently submitted a business case, backed up by robust data obtained from the centralised intake team, to obtain increased staff resources to help reduce waiting times to an acceptable level and in line with other localities in the region. The aim is for South Gloucestershire CAMHS to operate without a waiting list for all children and young people.

5.2.4 The children in need and child protection consultation team is an NBNHST wide team comprising of practitioners from community child health, CAMHS teams, named or designated professionals working in child protection and multi-agency colleagues. The team meets monthly and some team members sit on LSCB boards and sub-groups. The team is available for consultation regarding complex cases by professionals working in health, social care, education and police. They will also provide peer supervision to staff working in child protection. This is a good resource to practitioners holding severe, enduring or complex cases where professional advice might help when planning a way forward.

5.2.5 The current interim re-commissioning of NBHT children's community services (CCHP) for the period April 2016 to April 2017 poses risk in relation to the continuity of safeguarding vulnerable children and young people best practice across this period. However, work undertaken by commissioners ensures that those risks are both identified and kept to an absolute minimum for the period considered. The designated nurse for example, is ensuring that interim contracts will include that safeguarding children training and specific safeguarding supervision for practitioners will continue uninterrupted during the period and will likewise be subject to audit.

5.2.6 There is no multi-agency safeguarding hub (MASH) in South Gloucestershire, but discussions are ongoing with partner agencies and those providers bidding to take over the current work of the CCHP for the period 2016 to 2017. The CCG designated nurse for safeguarding sit on the Avon wide strategic MASH programme board and both the designated nurse for safeguarding and named doctor for safeguarding children sit on the South Gloucestershire MASH Project board.

5.2.7 Current relationships with the local authority safeguarding children team are described as 'healthy' and positive with thresholds to 'First Point', the single point of access for all referrals to children's social care, described as 'not exceedingly high'.

5.2.8 The designated nurse and designated doctor are both active members of the main South Gloucestershire safeguarding children board, executive board and sub-groups. The designated nurse also chairs the quality assurance sub-group. There are strong links between quality assurance, training and practice and mental health and GP engagement across the County.

5.2.9 We examined evidence of learning from serious case reviews undertaken in South Gloucestershire. Recommendations from the individual organisational reports provided by primary care, NBT, UHB and AWP and the multi-agency recommendations from the overview report were implemented and have since been audited to ensure continuity of practice across providers. This includes for example, ensuring health professionals routinely share information with multi-partner agencies and all professionals refer antenatal concerns early on in pregnancy and attend and provide reports to conferences and core groups and engage with fathers.

5.2.10 The designated doctor has chaired a police, health and social care task and finish group to develop guidance for injuries in non-mobile babies. Following a recommendation from a recent serious case review where a child died at a non-mobile age having previously sustained at least three minor injuries which were known to professionals. The guidance was launched in February 2015 at the SGSCB annual conference, with a multi-agency workshop to promote understanding of the guidance. This guidance has since been accepted by Bristol and North Somerset safeguarding children boards and has been made available for consideration to all LSCBs in the South West region through the South West child protection procedures group.

5.2.11 The guidance is being piloted across BNSSG and audited by the emergency departments at BRHC and Southmead hospital, and we were advised that a review group will meet in the autumn of 2015. The designated doctor is currently working with Barnardo's and parent groups to develop a parent leaflet to promote understanding of the guidance to parents of new-born infants. The deputy nurse director has contributed to five further SGSCB protocols which received approval during 2014-2015. These include the neglect toolkit, neglect strategy, child sexual exploitation, female genital mutilation and parental substance misuse protocols.

5.2.12 Southmead hospital ED has dedicated link safeguarding professionals within the team to support and promote safeguarding children practice within the department. These individuals meet with the trust's safeguarding team on a regular basis. ED is represented at the trust's safeguarding committee.

5.2.13 Guidance on identifying and safeguarding non-mobile babies who attend Southmead hospital ED with bruising or head injuries has been implemented following a recent serious case review. The guidance is however new and we were unable to establish how effectively this is being used because of the lack of exploration of safeguarding within the ED notes at Southmead hospital.  
**(Recommendation 1.1 at 1.1 above)**

5.2.14 We were told that where health visitors and midwives are co-located communication is reported to be good. However, there does not appear to be any formal process that benchmarks the standard required for effective communication between midwifery and health visiting. **(Recommendation 1.9 at 1.26 above) A letter will also be sent to Public Health informing them of this issue**

5.2.15 NBNHST have demonstrated that they are auditing their performance and effectiveness for the transfer of safeguarding information from midwifery to health visiting. We saw a quality assurance exercise document undertaken by NBNHST this year that reviewed the transfer of safeguarding information from midwifery to health visiting.

Highlights from this exercise revealed that of the records reviewed 42% of health visitors did not receive the form which alert them to the pregnancy and any safeguarding risks relating to this. A significant events profile (formerly known as family life events profile) was seen in only 1% of records reviewed during the quality assurance exercise and these had either not been completed correctly or in the correct manner.

Timely and effective communication and sharing of information helps to safeguard and protect children and young people.

5.2.16 In one case examined in health visiting we saw that a notification of a child's attendance at BCH ED took eight days to reach the health visitor. However, we were told that this was unusual and notifications of MIU and ED attendances are routinely received by the health visitor within 24 hours. It is important that information pertaining to a child is received in a timely manner to enable health visitors to action or follow up attendances as necessary.

5.2.17 The 0 to 5 age group skill mix team of health visitors based at 17 locations across South Gloucestershire are reported to have clear roles and responsibilities. Health visitors delegate duties to the skill mix team and supervise their practice accordingly.

5.2.18 We were told about challenges around the recruitment of health visitors during our inspection. A rolling recruitment programme has been established and the ongoing gap in recruitment is reported to have been recorded on the risk register. We were advised that reported current health visitor caseload sizes ranging from 360 to 400 felt manageable. However, the Institute of Health Visiting (IHV 2015) have welcomed the minimum floor standard of one whole time equivalent health visitor per 300 children aged five years and under. Caseload sizes in South Gloucestershire therefore exceeds the recommended minimum floor standard as suggested by the IHV. However the figures provided were not broken down further to identify if they are based on individual children or families. Lord Laming recommended that HV caseloads should not exceed 300 families or 400 children. **A letter will be sent to Public Health informing them of this issue.**

5.2.19 Records seen in health visiting were easy to navigate with entries found in the appropriate sections of the file. We were advised that there are no current plans to move towards paper light or paperless working. The family life events profile was seen to be completed appropriately in all cases examined.

5.2.20 School nurses reported that the movement into area of five to 16 year olds at a universal level are often not identified to them. There is a risk therefore that there are children and young people with unmet needs in the community.

One case sampled revealed that a child subject to a child protection plan on moving into the area is still waiting to be sent their health records from out of area. We were told that school nursing have no access to child health to help facilitate this. The safeguarding team have been notified of this case and we were advised that interventions will take place. **A letter will be sent to Public Health informing them of this issue.**

5.2.21 Audit of effective arrangements to identify and support the health needs of looked after children is predominantly carried out by medical trainees working with the designated doctor. This informs service development but also helps to educate the trainees on the importance and impact of health reviews.

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## 5.3 Training and supervision

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5.3.1 Children and young people attending the ED at Southmead hospital are cared for by professionals who have received appropriate training in caring for sick children. There is a good range of additional training available to adult ED practitioners and the department benefit from having a number of RSCNs.

5.3.2 All ED practitioners are expected to attend level three safeguarding children training. NBNHST have a recovery plan to ensure full compliance and are on trajectory to achieve this.

5.3.3 There is no formal opportunity for Southmead hospital ED practitioners to meet to discuss safeguarding within the department. The ED governance meeting does not have safeguarding as a standing agenda item. However, we are aware that senior staff meet bi-monthly and that safeguarding is regularly discussed. 'Hot debriefs' also take place following any incident to discuss lessons learned.

5.3.4 Community midwives, as caseload holders, would benefit from in depth one-to-one supervision sessions to ensure a degree of professional challenge in cases where increased support or intervention with vulnerable women is noted and potential risk is not overlooked. We saw that where individual cases are discussed in supervision, the nature of the discussion, responsible practitioners and any decisions made are not currently being recorded on the client's records. This means that patient notes are incomplete. (**Recommendation 1.12**)

5.3.5 We were told that all staff at the Yate MIU are compliant with level three safeguarding children training. Competencies are in line with the intercollegiate document 2014 and we were further advised that compliance is monitored. Training is a mixture of in-house study days which are facilitated by the safeguarding team and multi-agency level three LSCB training.

However, there is more to do to embed CSE enquiries within Yate MIU. Staff have received CSE training including signs and indicators and are planning to adopt an assessment tool which is workable within the unit but to date, and in records examined, questioning around CSE was variable. (**Recommendation 9.8**)

5.3.6 We examined evidence that demonstrated that safeguarding supervision is offered to Yate MIU staff and the team also holds monthly team meetings where safeguarding issues are a standing agenda item. Advice and guidance is available on an ad-hoc basis as required either from the MIU safeguarding lead or Sirona Care and Health safeguarding team.

5.3.7 Sirona Care and Health hold a quarterly 'safeguarding champions' meeting which is attended by a MIU Yate representative. The purpose is to enable effective information sharing between the board and practitioners and this is felt to be positive and beneficial



5.3.8 Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). We were advised that midwives at Southmead hospital are expected to complete a minimum of 13 hours of learning over a three year period and compliance is monitored by the director of women's and children's health. Competencies are therefore in line with the intercollegiate document.

5.3.9 Midwives have access to a range of multi-agency and intra-agency training opportunities facilitated by the safeguarding team and specialist midwives. These have recently included study days in relation to domestic violence and there are plans to hold further study days in relation to child sexual exploitation and mental health issues. Safeguarding training to the appropriate level helps ensure that all staff are competent at assessing, planning, intervening and evaluating the needs of new born babies and parenting capacity where there are safeguarding or child protection concerns. Reviewing and amending the current preceptorship programme to include safeguarding competencies would aid the learning and development of newly qualified midwives and prioritise this essential element of their role at an early stage of their professional career. (**Recommendation 1.13**)

5.3.10 Safeguarding supervision within the New Horizon specialist mother and baby unit forms part of clinical supervision and is not held separately to it. Likewise, cases discussed at supervision are not routinely recorded in patient records and actions decided upon do not go on to inform the care planning process with individual staff responsibilities recorded and specific timelines noted. The same is also true of CAMH services. (**Recommendation 6.2**)

5.3.11 The FNP workforce has received additional training to deliver the FNP licensed programme. All practitioners are trained to level three safeguarding as per intercollegiate guidance and can access additional training such as CSE awareness. Practitioners are provided with weekly one-to-one supervision with the FNP supervisor with cases selected by the practitioner using the signs of safety model and, or additionally, Kolb's reflective model. Additionally, three-monthly tripartite safeguarding supervision is conducted with the named nurse.

5.3.12 In health visiting we were told that compliance by the 0 to 5 workforce for level three safeguarding training was good. Compliance is monitored by management at personal development reviews and during safeguarding supervision. The trust has reportedly launched incentives to promote engagement and compliance such as freezing individual staff increments until training has been undertaken successfully.

Practitioners reported that they were offered one days level three safeguarding training every two years with access to themed updates throughout the year covering topics such as CSE and signs of safety training. We have since been informed that those practitioners are offered a range of training opportunities to ensure they complete a minimum of 13 hours of learning over a three year period to comply with intercollegiate document 2014. Practitioners are also encouraged to attend multi-agency training every three years.

5.3.13 We were told that newly qualified health visitors receive a clinical preceptorship and additional safeguarding preceptorship programme. We also saw evaluations of safeguarding training were completed by health visitors. Those seen during our review had scored their knowledge higher following training than they would have previously.

5.3.14 Newly qualified specialist community public health nurses (school nurses) are offered preceptorship and additional safeguarding preceptorship as part of their induction package. The professional lead we spoke with reported that most practitioners who have become qualified have already had extensive school nurse experience prior to completing the course. This is reported to be flexible to meet the needs of the staff.

5.3.15 We were also told that staff were trained by CAMHS and undertook an eight session course called 'mind out'. We were told that the managers are mindful of the needs of new starters with regard to their experience of mental health but we were not made aware of a formal process around the training and development of new starters to ensure they are competent and alert to assessing and meeting the needs of children and young people they may be supporting at a tier one or two in mental health.

5.3.16 We were told that the school nurse team are trained to level three safeguarding as per intercollegiate guidance. Managers oversee compliance when undertaking PDR and during safeguarding supervision. Additional training such as CSE awareness is available.

5.3.17 The designated professionals for children looked after are involved in a programme of training and development to promote the health of children looked after. The designated nurse runs the 'Promoting health and wellbeing' course for foster carers and has given training to locality children's social workers and GPs in promoting the health of looked after children.

5.3.18 We heard and saw evidence of a strong desire from health visitor practitioners to ensure best outcomes for children. Health visiting case records are paper files with hand written notes. All notes seen were signed and dated with legible handwriting and they were also clear and easy to navigate. However, although safeguarding supervision is usually recorded in the chronology and case notes of clients discussed in some cases seen this did not demonstrate a reflective discussion or clear action planning having taken place. Several cases examined simply stated that a safeguarding discussion had taken place with no mention of any outcomes, responsibilities or timelines included. We have since been advised that details of discussions are recorded separately in the family health needs section of the record and that the main entry should summarise and reference the detail held in another section of the records. This was not seen in records examined however. ***A letter will be sent to Public Health informing them of this issue.***

5.3.19 All CaSH practitioners currently have access to safeguarding supervision through multi-agency group meetings which are held quarterly. The meetings are attended by the named nurse team, Brook services, the police, looked after children services, MIUs etc. We saw evidence of minutes from the multi-agency group meeting which clearly demonstrated evidence of cases being brought forward for discussion by practitioners, including action plans. However, outcomes following discussion are not being documented in the patient's records. This means that the young person's health records are therefore incomplete. ***A letter will be sent to public health informing them of this gap.***

5.3.20 We were informed that all CaSH clinical staff access level three safeguarding training which is part of the UHBNHST training matrix. We were advised that current compliance is at 85%. Management maintain oversight of those practitioners that have become non-compliant with safeguarding level three training, and they have been encouraged to book onto the next available place if and when this occurs.

Practitioners are expected to attend core level three training within six months of starting a new post and then every three years for update training. Practitioners in more specialist roles are required to attend two full days of safeguarding training every year, which also includes training on writing reports for case conferences. We are further informed that practitioners are offered a range of training opportunities to ensure they complete a minimum of 13 hours of learning over a three year period to comply with intercollegiate document 2014.

Practitioners also have access to additional training which includes FGM.

5.3.21 In both GP practices visited all GPs had undertaken level three training in safeguarding children. They also attended the quarterly safeguarding children lead GP meetings chaired by the named GP, and they stated that they found these extremely valuable. It is expected that GPs attend a minimum of three half day level three safeguarding children training sessions over a three year period. This includes a mixture of single and multi-agency training, reflective learning and peer discussions.

Training needs are audited and the training provided is evaluated. A training log is maintained by the named GP and compliance by GPs is monitored.

5.3.22 Training for GPs during 2014-2015 consisted of four sessions covering sexual exploitation, female genital mutilation and learning from serious case reviews. During the year 116 GPs were trained by the CCG. As at the end of March 2015, 148 (75%) of GPs from 198 on the South Gloucestershire performers list were recorded as up to date with their training.

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# Recommendations

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## 1. North Bristol NHS Trust should:

- 1.1 Ensure IT systems used at Southmead hospital ED contain prompts for staff to ascertain any safeguarding concerns at the outset of triage rather than relying on staff professional curiosity to ask those questions at a later stage.
- 1.2 Ensure systems are in place at Southmead hospital ED to record accurately family details of children and young people in attendance, including detail of adults with parental or carer responsibilities.
- 1.3 Ensure systems are in place within midwifery services at Southmead hospital so that robust cover is provided in the absence of specialist midwives to ensure continuity of liaison.
- 1.4 Provide opportunity for midwives and health visitors to routinely share information, especially where vulnerability is identified.
- 1.5 Provide more opportunity for midwives to visit expectant mothers in their own home to aid better risk assessment.
- 1.6 Ensure robust procedures are in place for midwives to regularly ask questions of expectant mothers about domestic violence throughout their pregnancy and that answers are recorded and readily available for examination. This will also require audit.
- 1.7 Ensure information relating to safeguarding concerns is routinely recorded and readily accessible within hand-held notes in midwifery services and that this is subject to audit.
- 1.8 Ensure practitioners at Southmead hospital ED are appropriately trained and aware of how to articulate risk and provide clear analysis when making referrals to children's social care and that those referrals are subjected to robust audit.
- 1.9 Ensure systems are in place to prompt ED practitioners at Southmead hospital to record ethnicity of children and young people attending the unit and that practitioners are aware of the importance of doing so.
- 1.10 Ensure appropriate systems are in place to support midwifery safeguarding staff at Southmead hospital with administration duties.
- 1.11 Undertake formal evaluation of the role of the specialist midwife for teenage pregnancy.

- 1.12 Ensure patient records are complete within midwifery services by routinely recording supervision discussions and their outcomes.
- 1.13 Amend the current preceptorship programme in midwifery services to ensure safeguarding competencies are tested for all newly qualified staff.

**2. University Hospitals Bristol NHS Foundation Trust should:**

- 2.1 Revise methods and use of paediatric beds within BRHC ED to take into account the increasing numbers of children and young people attending in mental health crisis so that their needs can be met and discussed in confidence.
- 2.2 Ensure age related admission paperwork is used at BRHC ED for all children and young people up to age 18.
- 2.3 Ensure all young people admitted to wards at BRHC for medical treatment whilst awaiting formal CAMHS assessment are each formally risk assessed to ensure both their safety and that of others on the ward.
- 2.4 Ensure that routes to the ED at BRHC are clearly signposted throughout the building to avoid any confusion, especially for those people in distress.

**3. University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust should:**

- 3.1 Ensure that there are systems in place for all EDs and MIUs in South Gloucestershire to share attendance information regarding pregnant attenders with midwifery services.

**4. South Gloucestershire Clinical Commissioning Group should:**

- 4.1 Ensure GPs are regularly updated about the child protection and child in need population of South Gloucestershire including those that 'step down' from protection measures.

**5. South Gloucestershire Clinical Commissioning Group, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust should**

- 5.1 Ensure systems are in place to ensure ED and MIU practitioners are aware of multiple attendances at all MIUs and EDs in the County and that information pertaining to multiple attendances is notified to relevant GPs.

- 6. Avon and Wiltshire Mental Health Partnership NHS Trust should:**
- 6.1 Ensure information obtained at core groups is duly considered for inclusion in the care planning process within the New Horizon mother and baby unit at Southmead hospital and that voluntary agreements between patients and practitioners are regularly reviewed and recorded in patient records.
  - 6.2 Ensure all safeguarding discussions are recorded in client records on the New Horizon mother and baby unit along with actions planned and responsible practitioners.
- 7. South Gloucestershire CCG and North Bristol NHS Trust should:**
- 7.1 Ensure CAMHS practitioners are informed of all child protection and core group meetings so that they are better able to make informed decisions about the submission of evidence which might go on to inform safeguarding decision making processes.
  - 7.2 Ensure that designated nurse and named nurse roles for looked after children across South Gloucestershire are up-to-date and fit for purpose according to duties undertaken by practitioners.
  - 7.3 Ensure IT systems currently used by CAMHS practitioners are 'fit for purpose' to support those practitioners in their work.
  - 7.4 Improve relationships between GPs and school nurse services by ensuring information is shared efficiently and more routine meetings between services are facilitated.
- 8. South Gloucestershire CCG and Avon and Wiltshire Mental Health Partnership NHS Trust should:**
- 8.1 Ensure risk assessments are regularly reviewed within adult mental health services and, where required, they are updated accordingly and the process is recorded in client notes.
  - 8.2 Improve current arrangements for accommodating children and young people in mental health crisis under section 136 of the Mental Health Act 1983, ensuring appropriately trained staff are available at all times and that accommodation used to provide care and support to vulnerable children and young people is fit for purpose.

## 9. South Gloucestershire CCG and Sirona Care and Health should:

- 9.1 Ensure all fields on admission paperwork at Yate MIU is completed by way of introducing mandatory fields in electronic notes used and that their use is subject to robust audit.
- 9.2 Ensure systems are in place to prompt practitioners at Yate MIU to ask questions of adult attenders of their parental and caring responsibilities to children and young people.
- 9.3 Continue development of the follow up process for young people who do not wait for treatment at Yate MIU and implement a formal process at the earliest opportunity.
- 9.4 Ensure practitioners at Yate MIU are provided with regularly updated information pertaining those children and young people subject to child protection and child in need procedures in the South Gloucestershire.
- 9.5 Ensure a formal frequent attender policy under development is in place at Yate MIU at the earliest opportunity and that its use is monitored by audit.
- 9.6 Ensure staff at Yate MIU are made aware of vulnerabilities and risks to children and young people by way of systems to 'flag' safeguarding alerts to them for children and young people in attendance and that they too can update colleagues with any concerns they might have.
- 9.7 Ensure policies and systems are in place to ensure all staff working at Yate MIU are trained and supervised according to intercollegiate guidance and practitioner roles and responsibilities are clearly defined.
- 9.8 Ensure prompts and systems are in place for staff at Yate MIU to appropriately ask and record questioning in relation to CSE.

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## Next steps

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An action plan addressing the recommendations above is required from South Gloucestershire CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.