

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

Children Looked After and Safeguarding

The role of health services in Somerset

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CCGs included:	Somerset CCG
NHS England area:	NHS England South West
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Summary of the review

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

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

About the review

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

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

How we carried out the review

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

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

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

In total, we took into account the experiences of 148 children and young people.

Context of the review

Somerset is a rural county in the south west of England covering an area of 3,452 km². Although there are pockets of socio-economic deprivation, overall the population is less deprived when compared with the national average, although there is recognition that the rural nature of the county presents challenges in terms of equity and access to health and social care services. The county consists of five districts, Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset, with one in four people living in the larger towns of Taunton, Yeovil and Bridgwater.

*Residents of Somerset are mainly registered with **NHS Somerset Clinical Commissioning Group** (CCG). It should be noted however, that small numbers of Somerset residents are registered with other CCGs, including NHS Bath & North East Somerset CCG, NHS Dorset CCG, NHS North, East, West Devon CCG, NHS North Somerset CCG and NHS Wiltshire CCG.*

Approximately 109,000 children and young people under the age of 18 years live in Somerset. This is 20.2% of the total population in the area. Approximately 15% of the local authority's children are living in poverty.

Children and young people from minority ethnic groups account for 3.5% of all children living in the area, compared with 19.5% in the country as a whole. The largest minority ethnic groups of children and young people in the area are White Other, Mixed and Asian/Asian British. The proportion of children and young people with a first language other than English: in primary schools is 5.0% (the national average is 18.7%) and in secondary schools is 3.6% (the national average is 14.3%).

Polish is the most common non-UK nationality in all Somerset districts and Polish-born residents now account for 1% of Somerset's overall population. There are significant pockets of Polish-heritage residents in parts of Shepton Mallet, Yeovil, Minehead, Taunton and Bridgwater. A large traveller and Eastern European population seeks seasonal work in the agricultural parts of the county, but is not resident.

At 31 January 2015, 472 children and young people were the subject of a child protection plan. This is an increase from 412 at 31 March 2014. Eighteen per cent of child protection plans show that children are living in households where mental health issues, drugs and alcohol are significantly affecting the care that children receive. Emotional abuse, at 43%, is the highest category for children placed on a plan, with 34% of plans showing neglect as the main reason.

At 31 January 2015, 482 children were being looked after by the local authority (a rate of 44 per 10,000 children). This is a reduction from 488 (45 per 10,000 children) at 31 March 2014.

Of this number:

- 129 (or 26.8%%) live outside the local authority area*
- 48 live in residential children's homes, of whom 40% live out of the authority area*
- 10 live in residential special schools, of whom 6 live out of the authority area*
- 357 live with foster families, of whom 24.1% live out of the authority area*
- 17 live with parents, of whom 5.9% live out of the authority area*
- 1 child is an unaccompanied asylum-seeking child.*

Nationally published data as at 31 March 2014 shows that the take-up of dental checks by looked after children is higher in Somerset, at 86% of children, than the England average of 84%.

The Hidden Harm Needs Assessment in January 2015, indicated that in the six months April – September 2014, 715 parents were accessing a structured drug treatment programme, in comparison to 208 parents accessing a structured alcohol dependency programme. Supporting the Joint Strategic Needs Assessment (JSNA) report, a Hidden Harm assessment was undertaken which showed that 18% of the 465 children with a child protection plan in place are living in families where drugs, alcohol, mental health and domestic abuse present as significant factors in their lives. The assessment showed an estimated 6,300 children in Somerset are living in households where domestic abuse is a regular occurrence, and 800 of these households are considered high risk

Commissioning and planning of most health services for children are carried out by Somerset Clinical Commissioning Group

Commissioning arrangements for looked-after children's health are the responsibility of Somerset Clinical Commissioning Group (CCG). The designated nurse for children looked after is employed by the CCG and the designated doctor for children looked after is employed by Taunton and Somerset NHS Foundation Trust. The operational looked-after children's nurse/s, are provided by Somerset Partnership NHS Foundation Trust.

Acute hospital services are provided by Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust and commissioned by Somerset CCG.

School nurse services are commissioned by Somerset County Council and provided by Somerset Partnership NHS Foundation Trust.

Health visitor services are commissioned by NHS England South West sub regional team and provided by Somerset Partnership NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Somerset County Council and provided by Somerset Partnership NHS Foundation Trust

The integrated young people's and adult's substance misuse service is commissioned by Somerset County Council and provided by Crime Reduction Indicatives (CRI), Turning Point and Developing Health and Independence (DHI) working as Somerset Drug and Alcohol Service

Tier 2, 3 and 4 Child and Adolescent Mental Health Services (CAMHS) are provided by Somerset Partnership NHS Foundation Trust. Tiers 2 and 3 CAMHS are commissioned by Somerset CCG, and Tier 4 CAMHS is commissioned by NHS England South West sub region

Specialist facilities (e.g. SARC) are provided by United Hospital Bristol NHS Foundation Trust commissioned by Public Health England

Adult mental health services are provided by Somerset Partnership NHS Foundation Trust and commissioned by Somerset CCG

The last inspection of health services for Somerset's children took place in 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Of the six outcomes that were given aggregated inspection findings, four were marked as adequate, health's contribution to safeguarding was good and being healthy for looked after children was inadequate. Recommendations from that inspection are covered in this review.

The 2013 Ofsted inspection found that the overall effectiveness of the arrangements to protect children in Somerset County Council were inadequate. Ministerial intervention followed with a warning notice being sent to the council. A Children and Young People's Service Improvement Board has been in place in Somerset since 2012 with a ministerial advisor being in attendance to observe. Somerset CCG has been participating in the improvement board to improve safeguarding arrangements for children and young people across all partner agencies county wide.

The recent Ofsted inspection found the LSCB to be inadequate although did identify progress on health assessments. The health looked-after child team recently co-located with social care.

Following a series of interim Directors of Children's Social Care and senior managers in the local authority, the new substantive Director of Children's Services took up post a few weeks prior to this CQC CLAS review.

A Multi-Agency Safeguarding Hub (MASH), to manage initial concerns about children and young people was formally established in September 2014.

The report

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

What people told us

We heard from young people using a school nurse drop-in clinic who told us;

"It's great and you can trust them. I like the things they can show us, like the tar in the jar and the drugs box, I never thought about how smoking and stuff could affect you but now I've seen it for myself"

Young people involved with child and adolescent mental health services (CAMHS) told us:

"At Wessex House, we influenced choices about furniture, meal choices what staff wear; the use of the seclusion room and restraints. We provided training to receptionists, support workers and nurses. It was really well received."

“The transition from CAMHS into adult mental health has been such a big change. Not enough time was given to introduce the new worker.”

“The Outreach team was really helpful and worked with me longer than usual as I had changed schools a few times which had disrupted me”

“It is really hard to change worker if you don’t feel the relationship is working. It does come up in the participation group from time to time. It isn’t made clear who to speak to if you have issues with your worker.”

“Young people are not always involved with their care planning and don’t always get copies of their plans in the CAMHS and learning disability services.”

“The experience of going to the ED is very dependent on individual doctors and nurses. Sometimes they make unhelpful remarks about the marks on my arms. Being on the ward all depends on what staff you get too. Not all nurses have much understanding of mental health.”

“Such a long wait for CAMHS! It seems like you have to be on death’s door or really hurting yourself. It took 3 or 4 months to get assessed. The crisis line is there to help while you wait. Once I was with CAMHS, help was swift.”

“There is no help for mental and emotional health at school. I feel there is such a stigma”

“It’s good being involved in the interview process. I was on the interview panel and I felt really uncomfortable with the person the panel wanted to appoint. She wasn’t appointed.”

We spoke to a mother with a new born baby who told us about her ante-natal care;

“The midwives have been wonderful; I was offered groups to go to”

A mother whose baby was being cared for in the special care baby unit (SCUBU) told us;

“It is good that I can spend as much time as I want with my baby. The midwives help me, the nurses are lovely and I can talk to them if I’m feeling a bit low”

The child's journey

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

1. Early help

- 1.1 Somerset CCG, Somerset County Council and other partner agencies recognise that Early Help is a significant and priority area for development across the county. While we found Early Help to be underdeveloped overall, we did see individual case evidence of some good joint working between services: in cases involving midwifery, health visiting, adult mental health, CAMHS, social workers and family support workers.
- 1.2 We heard about a wide range of accessible parent craft and support options available for expectant and new mothers across both midwifery service areas. All expectant mothers registered with Yeovil District Hospital NHS Foundation Trust can access physiotherapy, aqua-natal, weekend parent craft, peer support groups, smoking cessation and breast feeding support. Additionally, parents under 19 years can receive targeted support from the YIPI young parent group.
- 1.3 Taunton and Somerset Foundation Trust (TSFT) midwives aim to visit all new expectant mothers at home during their ante natal period; this allows midwives to assess the home conditions and is recognised best practice; being a valuable source of information on potential risk. However, while Yeovil District Hospital NHS Foundation Trust (YDHFT) midwives operate a flexible booking including evening/weekend sessions and ante natal/post natal drop in sessions, to facilitate access to midwifery and other Early Help support, midwives do not undertake ante natal home visits. All bookings take place at community hospitals, children's centres or GP surgeries. As a result, YDHFT midwives are unable to assess home environment and social factors. This may result in risk assessments which are not fully comprehensive and is an area for the service to develop in order to ensure risk assessment practice is fully rigorous (**Recommendation 1.1**).
- 1.4 Expectant women who do not attend their ante natal appointments are followed up and in cases we reviewed where women had poor engagement with community midwives, these cases were appropriately escalated to children's social care.

- 1.5 In all case records we saw, midwives had recorded the details of the expectant woman's partner and whether the partner is the father of the child. This did not include questions about paternal health and lifestyle choices, however, that may have an impact on the unborn or new-born (**Recommendation 2.1**).
- 1.6 Midwives try to see expectant women alone during the ante natal period and record this on the hospital notes, although we noted that this does not happen in all cases. Neither YDHT nor TSFT include information about the expectation that women will be seen alone on one or more occasions during pregnancy. Inclusion of this expectation in the information given to the woman at the outset would help to establish this as routine practice and any refusal by the woman's partner would be a useful indicator of risk. When women are seen alone this allows confidential discussions to take place, including disclosure of domestic violence if this is present and best practice would be for all mothers-to-be to be seen alone on at least one occasion (**Recommendations 2.2**).
- 1.7 Risk assessment of vulnerability in Taunton and Somerset NHS Foundation Trust midwifery services is not always repeated during pregnancy and this is a missed opportunity to identify any change or emerging concern not evident at the initial assessment. Cases seen in the Yeovil District Hospital Trust service also highlighted gaps in risk assessment and further exploration of vulnerabilities throughout the pregnancy (**Recommendation 2.3**).
- 1.8 There is more to do to ensure that effective information sharing systems are in place and that communication between GPs and midwifery services is robust. Information from primary care is not routinely available or considered when midwives are booking pregnancies. GPs told us that midwives do not attend primary care vulnerable families meetings or run clinics from surgeries. As a result GPs told us that they feel disengaged from information on expectant women. This also means that midwives are not always in receipt of all information which may contribute to a risk assessment and there is an over reliance on an expectant mother to disclose issues. (**Recommendation 3.1**).
- 1.9 In all midwifery cases sampled in both YDHT and TSFT, clear individual birth plans for all women were in place and this is good practice.
- 1.10 Health visitors are commissioned to carry out the full universal Healthy Child programme including the ante natal contact. The number of ante natal contacts made continues to increase with approximately 70% of all new families visited in the ante natal period. This increase is, in part, due to the more effective and timely notifications of booked pregnancies from midwifery to health visitors.

- 1.11 Effective arrangements are in place to ensure that new families with children under 5 who move into Somerset are contacted and seen in their new home. This helps to support families, introduce them to local services and identify any vulnerability or other health need.
- 1.12 All cases sampled in school nursing, highlighted good multi-disciplinary and inter agency communication and liaison; with the school nurse acting as an effective bridge between health and education. Weekly drop in sessions offered to all local secondary school are prioritised by the service and provide a highly effective way to engage with young people at an early opportunity for both targeted and health promotion work. Young people using these drop-ins spoke highly of what it offered.
- 1.13 Reception staff at Musgrove Park Hospital emergency department (ED) check demographic details, the next of kin and who is accompanying the child or young person and this is good practice. However, there is no effective flagging system in place at either Musgrove Park and Yeovil District Hospitals, to identify children with known vulnerabilities. Staff are reliant on a parent, carer or young person telling them that there is a social worker involved with the family (**Recommendation 2.4**).
- 1.14 At Musgrove Park Hospital, there is no safeguarding triage to check for non-accidental injury or other child protection concerns as recommended by NICE and the department does not use a separate paediatric version of the ED record. Also in some records seen of infants who had attended Musgrove Park Hospital ED following head injury, we were not assured that the ED was compliant with NICE guidance on assessing and treating children with head injuries (**Recommendation 4.1**).
- 1.15 In treating adults, Musgrove Park Hospital ED practitioners are, however, vigilant in recording details of other children in households and also the names of other adults in household and this is direct learning from serious case reviews nationally. Cases that need further investigation or where a family is identified as needing additional support are noted in a book, this diary is then reviewed each working day by a member of the safeguarding children team and either the concern is referred to children's social care or discussed with the child's health visitor or school nurse. The system works well and we saw good identification of need for children, young people and of those adults who present to the ED with risk taking behaviours who have children.
- 1.16 At both ED sites, there is an over-reliance on practitioners asking the questions of adults to identify potential hidden harm and there are no formal prompts in YDH documentation or space to record this detail. Think Family is not well embedded and there is a lack of awareness of the hidden child who may be affected by parental health issues. (**Recommendation 3.2**).

Case Example: *A father brought a four year old child to the emergency department (ED) following a seizure.*

While waiting for the child to be admitted to the paediatric ward, the father left the ED with the child. The father had asked the ED nurse allocated to escort them to the ward to come back in a few minutes whilst they waited for Mum. He left the hospital in the meanwhile.

The ED staff acted promptly and contacted police who got the parents to bring the child back to the hospital.

This was prompt and appropriate action by the ED practitioners to safeguard a potentially vulnerable child. However, patient records showed that the child was later discharged from the paediatric ward with limited probing of the case circumstances or consideration of any potential safeguarding issues.

- 1.17 Details of attendances at ED are shared with the child's GP, health visitor or school nurse. However, the detail is very limited and only includes the reason for attendance.
- 1.18 There is no formal agreed pathway between either of the acute hospital trusts' emergency departments and the young people's substance misuse service, Somerset Drug and Alcohol Service (SDAS), although there is an SDAS member of staff working in each hospital. This is a missed opportunity to identify and respond to any emerging concerns early: to share information and ensure the safe transition of a young person to an appropriate service (**Recommendations 3.3 and 5.1**). ***This issue has been drawn to the attention of Somerset County Council as the commissioner of the Somerset Drug and Alcohol Service.***
- 1.19 At Yeovil District Hospital ED, children are triaged quickly by appropriately trained staff and there is discrete paediatric documentation which is NICE compliant. Cases we reviewed demonstrated that the paediatric assessment documentation is consistently completed.
- 1.20 At Yeovil Walk-in Centre, the practice safeguarding lead reviews all new patients. This provides an opportunity to identify any vulnerabilities or safeguarding concerns early and is exemplary practice. Safeguarding information flows effectively within the practice and between the practice and health visiting service so that relevant staff are aware of current and evolving risks to individual children and can respond to increased risk effectively. We saw case examples of receptionists and practitioners responding promptly to concerning behaviour and taking appropriate safeguarding action. Practice staff told us of delays in receiving information about children from Yeovil District Hospital Trust following attendance at the ED and we saw case evidence of this. This reduces the opportunities for the practice to identify vulnerabilities and take early action where necessary.

- 1.21 Young people have good access to emergency contraception through a network of trained pharmacists, minor injuries units and the local emergency departments. Teenage parents can be referred to the young parents' programme which is started in the antenatal period. This work extends into the post natal period and has been positively evaluated by young parents and professionals.

Good Practice Example: *Somerset Partnership NHS Foundation Trust school nurse service operates a highly successful model of weekly drop-in clinics across Somerset.*

All local secondary school are prioritised by the service which offers young people support and advice on contraception and sexual health, emotional health and wellbeing. The service is non-threatening, young people friendly with a health promotion aspect as well as offering 1:1 support from two practitioners at every clinic.

The service is highly valued by schools and by young people, some of whom told us;

"They're really supportive and friendly"

"The service is good, quick and helpful"

2. Children in need

- 2.1 We heard how the Common Assessment Framework (CAF) is not well developed across Somerset, with no agency taking overall responsibility and poor operational accountability. We saw case examples of complex families, often supported by many different professionals across health, education and social care in an uncoordinated way. Slow progress is now being made with the establishment of CAF. The priority being given to the development of Early Help and CAF by the director of children services would be expected to see this progress continue.
- 2.2 Recently it was agreed that all expectant teenage mothers will have a pre-CAF assessment and these are being undertaken. Midwives are sharing this CAF information with the health visitors for young people where these are in post across Somerset. This should be helpful in ensuring young mothers get access to early support although we know that this is not well developed and the midwives we spoke with are unsure of how the provision of CAF will affect outcomes

- 2.3 We saw evidence of solid midwifery practice at the frontline on individual cases. We also saw strong evidence in some cases, of the tenacity of specialist midwives in highlighting the vulnerabilities and risks to unborn infants to other professionals in order to promote good outcomes. This is from a low base however, and there is more to do to ensure consistent, high quality midwifery safeguarding practice is embedded across the county.
- 2.4 Expectant women who have additional vulnerability who book their pregnancies at Musgrove Park Hospital (TSFT) are supported well by the Juniper team of midwives. The Juniper team consists of a full time teenage pregnancy midwife who caseloads expectant teenage mothers aged under 17 at the time of booking. She provides consultation to community midwives for all under 19's should this be required. There are also specialist TSFT midwives who provide consultation to community midwives and provide additional support for expectant women with substance misuse and alcohol needs and also additional mental health needs. We saw how Juniper midwives support vulnerable families well, through enhanced ante natal contact and by accompanying mothers to consultant appointments. We saw good support of expectant women with substance misuse concerns, including good liaison between the specialist midwife and local adult substance misuse practitioners to protect and safeguard the unborn child.

Case Example: *A woman booked her pregnancy and during the booking disclosed a history of substance misuse to the midwife and her continued engagement with adult substance misuse services as she was stable on a methadone prescription.*

The midwife recorded the woman's partner's details, his social vulnerability and details of his older children who lived independently in another part of the country. The midwife completed a comprehensive communication form which clearly identified risk, resilience factors and a care management plan.

A referral was appropriately made to children's social care, though this was weak in quality and did not clearly assess or articulate risk to the unborn child.

The substance misuse midwife worked closely with the adult substance misuse service to monitor compliance and engagement with services. The substance misuse midwife created a comprehensive birth plan and once baby was born, a discharge planning meeting took place.

Midwives on the post-natal ward observed that mum was falling asleep holding the baby. They felt this was a risk and recorded that they would advise children's social care, however, there was no record on the patient notes to indicate that this was done.

Mother and baby were discharged home

- 2.5 Where TSFT community midwives identify vulnerability or risk they complete a communication form which is then shared appropriately across primary care and with the health visitor. Communication forms seen by inspectors were comprehensive and articulated risk clearly, leading to good quality clear planning for ante natal, labour and post-delivery care.
- 2.6 In Yeovil District Hospital Trust midwifery service, the expectation is that risk identification forms should be filled in as soon as risks are identified and updated throughout pregnancy. These are expected to be distributed promptly to the appropriate GP, health visitor and maternity delivery team. Many case records that we sampled did not include the risk assessment documentation or subsequent updates. Not all Yeovil community midwives conducting ante-natal clinics in primary care settings are ensuring that key safeguarding information about families with domestic violence issues is shared with the GP practice. The mechanism therefore, by which key health professionals are alerted to additional needs and vulnerabilities likely to affect the unborn child, is not fully effective. This creates significant potential for risks to the children to be missed by the practice which may be unaware of emergent concerns about a family (**Recommendation 1.2**).
- 2.7 YDHT Midwifery do not directly receive domestic violence notifications. These are filtered through the community provider and then sent to midwifery, this creates added delay and means midwifery cannot always provide support in a timely manner. In one case example, there was a three month delay in the midwifery team being informed about incidents of domestic violence in a family where the woman was pregnant. ***This issue has been drawn to the attention of Somerset County Council which commissions the domestic abuse service.***
- 2.8 Whilst there are specialist midwives in Yeovil District Hospital Trust for vulnerabilities including young mums, young people who are looked after and those who have substance misuse issues; there is a gap in support arrangements for women with mental health needs. Given that specialist support is available to mothers delivering at Musgrove Park Hospital, there is a risk that new mothers at Yeovil District Hospital with similar needs may not be sufficiently supported. (**Recommendation 1.3**).
- 2.9 Regular meetings take place between Somerset Partnership NHS Foundation Trust (Sompar) health visitors and the YDHT Acorn and TSFT Juniper vulnerable midwifery teams to discuss families where additional need has been identified. This helps to ensure expectant women receive a co-ordinated package of care as early as possible. Midwives and health visitors are co-located in some outlier villages. These are positive factors contributing to improving liaison between midwives and health visitors which facilitates early contact with a vulnerable family and seamless support into the post-natal period.

- 2.10 New families have access to a wide range of ante natal and early years support including listening visits for mothers with mild to moderate depression and post natal groups around parenting and attachment. While we heard about good outcomes from the Horizon programme, better known as Mum's Time, run by a health visitor specialist in perinatal mental health, there is no specialist perinatal mental health pathway in Somerset that is NICE compliant. This is a significant gap (**Recommendation 5.2**).

Case Example: *39 year old mother with borderline personality disorder who had long term engagement with the mental health service. She was referred to Mum's Time, part of the Horizon Programme run by a mental health specialist health visitor.*

Initially reluctant, she attended her first group 3 years ago but was very withdrawn and did not really engage. The health visitor worked with her through telephone contacts and also worked with the woman's partner who was father to the child. At the time, the child was suffering due to mother's neglect and poor interaction with him.

Over the period of her engagement with Mum's time there have been significant beneficial outcomes;

- The woman has a better understanding of her mental health issues and uses strategies she has learnt in the group to manage her emotional health and behaviours*
- She still gets support from mothers she met at the group*
- She has developed her own successful jewellery making business*
- She has improved self-esteem and parenting capability*
- Her partner also has made positive use of the coping strategies*
- Her child has thrived and has a good attachment with the mother*

- 2.11 In health visiting, where we saw Family Health Needs Assessments regularly reviewed and kept updated, these detailed well, the past and emerging need in vulnerable families. However, these family health needs assessments are not always reviewed and updated regularly, reducing their beneficial impact in individual cases. On occasion, we saw an over-reliance on self-reporting by parents in the service and found that health visitors were not always demonstrating professional scepticism in seeking verification of information they were given.
- 2.12 School nurse team leaders have clear expectations that handovers from health visitors to school nurses will be face to face in cases where there are known vulnerabilities or safeguarding issues. An electronic template has been put in place to support this and we saw case evidence that robust handovers of vulnerable cases take place. This ensures relevant information is exchanged on important safeguarding issues and helps to protect vulnerable children.

- 2.13 We saw evidence of some close GP and health visitor working to support vulnerable families. Similarly, in individual case records seen in school nursing, GP liaison was robust and information was exchanged quickly and easily, with the school nurse initiating contact and helping to ensure young people's needs were being met appropriately. Health visitors routinely attend GP Practice or vulnerable families meetings where these are established and each GP practice has a named link health visitor. School nurses are not routinely invited to attend these meetings, although school nurses felt that they have good communication lines with GPs when necessary. Lack of capacity in the service, significantly limits the ability of school nurses to attend GP practice meetings or vulnerable families meetings where these are being held. Not all GP practices have vulnerable families meetings in line with best practice however, and this is a gap in the development of effective early help in primary care (**Recommendation 6.1**).
- 2.14 GP practices across the county have a lead GP for safeguarding and in one surgery we visited; we saw evidence of the other GP's accessing this practitioner for support and advice on next steps if they had any safeguarding concerns.
- 2.15 At Yeovil District Hospital, facilities for young people in both the ED and on the paediatric ward are appropriate, with specific bays for different age ranges including for vulnerable older teenagers aged 17 -24 years.
- 2.16 Cases sampled at YDHT highlighted good access to a responsive child and adolescent mental health (CAMHS) assessment service which is available for young people presenting in business hours. However, aside from an on-call psychiatrist who covers the whole of Somerset, there is no additional out of hours' service. This could result in young people remaining as inpatients waiting for mental health assessment over a weekend when they are clinically fit for discharge.
- 2.17 Children and young people who attend either Musgrove Park or Yeovil District ED Hospitals following an incident of self-harm or needing urgent support for their mental health, are cared for appropriately. Young people are admitted to the paediatric ward for a period of cooling off as advised by NICE and are seen the next working day by CAMHs. We were told that 16-18 year olds may be seen by the adult mental health crisis team but that this is not typical.
- 2.18 We saw case evidence at Yeovil District Hospital paediatrics that for young people who are repeat attenders that are known to CAMHS and adult mental health, agreed care and safety plans are in place developed jointly with CAMHS and the adult mental health service. This is good practice, sensitive and supportive of young people with recurrent admissions due to mental ill health.

- 2.19 CAMHS do fund additional staffing as necessary to support the care of the young person if they need an extended stay; for example while the young person is waiting for an appropriate in-patient placement. Nursing staff routinely complete risk assessments for each young person, however, environmental risks such as potential ligature points are not always considered (**Recommendation 3.4**).
- 2.20 Paediatric ward staff at Yeovil District Hospital have not accessed generic training on how best to support young people with mental health needs on the ward, but have had individual advice on a case by case basis (**Recommendation 1.4**).
- 2.21 There is a recognised gap in early help for young people with low to moderate levels of mental health needs. Young people told us about long waits for service and how needs can escalate. The CAMHS service is improving waiting times for assessment and subsequent intervention as a priority supported by increased investment over recent time by the CCG and there is work in hand to establish a 0-25 pathway. We saw and heard case examples demonstrating beneficial outcomes for young people once they were engaged with the service, however. Young people also gave us very positive feedback about the outreach service.
- 2.22 The approach to care planning in CAMHS is variable and young people are not always involved in developing the plan and don't always receive a copy. However, we did see an example of exemplary care planning and sharing of relapse indicators and crisis plan. This was highly focused on the young person and shared with all appropriate services involved with the young person (**Recommendation 5.3**).
- 2.23 Direct communication between CAMHS practitioners and GPs is not as well developed as it could be although we did hear some good practice examples.

Case Examples: Case A - 15 year old female was having support from a CAMHS worker. Concerns had been identified that she may have an eating disorder. As part of her care plan, she was to have her weight checked regularly by her GP. The young person was reluctant to do this as she did not believe she had any eating disorder. The CAMHS worker liaised well with the GP and undertook follow-up phone calls with the GP to check the young person had attended surgery and to discuss the young person's progress. This is good practice.

Case B – A CAMHS worker developed a care plan with the young person's full participation. The plan was clearly written in young person friendly language. Relapse indicators and relapse plan for when her mental health was deteriorating were identified and, with her full agreement, shared with all the key services the young person was likely to access when ill. These services included the MIU, ED at her local acute hospital and the ED at the acute hospital where her mother lived as she also accessed this service on occasion and the paediatric wards in the relevant two acute hospitals.

The relapse plan set out how the young person wanted to be supported and cared for when she was becoming ill and how she wanted to be treated if she needed to be admitted to hospital. The plan also included which hospitals she did not want to be admitted to.

This care plan was clearly very much the young person's own. The young person's anxieties about how she might be treated if she became ill decreased as she was confident that the practitioners involved fully understood her needs and wishes, putting her in control. This makes this care plan an exemplar.

- 2.24 It is hard for young people in Somerset to express a wish to change CAMHS worker; where this had been raised, a change was made promptly to the benefit of the young person. There is scope for the service to work more closely with the excellent participation group to help improve the service. Young people were closely involved in the development of the new T4 in-patient provision and gave us positive feedback about this engagement and the new service (**Recommendation 5.4**).

3. Child protection

- 3.1 We saw a number of case examples that demonstrated effective information sharing and close, co-operative working between children's social care and health to protect children at risk. However, there were key areas of deficit across the agencies which undermined the effectiveness of safeguarding and child protection arrangements in cases where children were known to be at risk or where potential high risk had been identified.
- 3.2 There was a significant and urgent area for development across all health providers including in primary care and adult services, in how health practitioners across services make referrals to children's social care. We found for the most part, that health practitioners made referrals appropriately in response to correctly identified vulnerabilities and safeguarding risk. However, we saw highly variable approaches across the health economy and within individual services in the methods used in making these referrals which significantly undermined the effectiveness of the safeguarding of children and young people.
- 3.3 The best and most consistent practice seen was in the Taunton and Somerset NHS Foundation Trust midwifery service, where referrals are usually made using the local authority's electronic multi-agency referral form. These are then copied to the safeguarding lead midwife with a hard copy printed off and retained on the hospital patient record. This ensures a robust audit trail for the referral and facilitates operational oversight and managers' opportunities to quality assure referrals across the service as part of continuous improvement and practitioners' professional development.
- 3.4 In other services, telephone referrals were not routinely followed up in writing. We were told that YDHT midwifery services send referrals electronically and retain a hard copy record in the medical records. However, in cases we reviewed, we saw no evidence of the detail of the referral being retained in the case record. In the ED at YDHT, there were no records on patients' clinical notes of referrals having been made. There is no audit trail to ensure that risks have been acted on and appropriately referred to children's social care. This is very poor practice and increases risks to children.

- 3.5 It was difficult for inspectors to review actual examples of referrals to assess their clarity and quality as services were unable to produce examples for evaluation. Those we did review evidenced, for the most part, poor quality. This included the referrals made by TSFT midwives. Child safeguarding and child protection referrals that we were able to evaluate did not routinely set out a clear rationale for the referral or clearly articulate the risk of harm to the child. Neither did they set out what was the referrer's expected outcome. All of these elements are key in making good quality referrals which support effective decision making in children's social care (**Recommendation 7.1**).
- 3.6 We saw no evidence that health practitioners make use of thresholds documentation to guide their formulation and composition of referrals to children's social care, although midwives at Musgrove Park hospital demonstrated that they understood children's social care thresholds for referral.
- 3.7 Use of chronologies in midwifery services was inconsistent and not established as expected routine practice. This makes it difficult for practitioners and managers to quickly establish key events and this finding is often a feature of serious case reviews (**Recommendation 3.5**).
- 3.8 Health visitors create chronologies of significant events on their electronic record system. However, chronologies seen are not meaningful and do not reflect the complexity of work with families. Instead, there is an over reliance on the IT progress notes. Records seen show that, on occasions, information is not being shared across family records and this means that important information may not be available to a practitioner working with a child, especially where there has been a change in health visitor (**Recommendation 5.13**).
- 3.9 A pre-birth protocol is in place between both TSFT and YDHT midwifery services and children's social care identifying key dates and responsibilities around protecting the unborn child. Not all midwives were aware of this however and compliance within the services is low. Pre-birth conferences are not always held on time and worryingly, we found an increasing trend towards a reliance on extended post natal stays in maternity wards whilst arrangements for the new born infant are finalised. This is not acceptable (**Recommendation 2.5**).
- 3.10 Child protection paperwork is not currently held on the Musgrove hospital midwifery record. This means that the record is incomplete and is not good practice. Midwives, however, were recording notes from discharge planning meetings and birth plans seen were comprehensive and protected the newborn child well.

Case Example: *A teenage expectant mother attended a midwifery service for booking at 18 weeks. At booking she advised that she had a history of twins who were in the care of the local authority.*

There was good identification of early risk by the midwife and the baby's father's details were obtained. The Communication form completed by the midwife was comprehensive and an appropriate management plan was put in place. A pre-birth planning meeting was held and a comprehensive birth plan also put in place.

However, the case record does not contain any child protection documentation issued by the local authority or reports produced by midwives.

The patient record shows discussion between the GP and the midwife when new information was disclosed around the woman's previous mental health history and self-harm. Unfortunately, this information did not result in a review of current planning and support for her post-delivery. This was a missed opportunity to support a vulnerable young mother in a potentially difficult period if the baby was removed.

In the event, discharge planning took place and mother and baby settled in a joint foster placement.

- 3.11 There is no stand-alone female genital mutilation (FGM) policy in place at YDHT although FGM is included in the trust's safeguarding policy. While FGM is not deemed to be prevalent across the county; YDHT identified only one case in eight years, the picture nationally is one of increasing risk and occurrence and all provider trusts need to ensure that practitioners are well equipped and supported in assessing risk and responding appropriately to incidents of FGM through the provision of appropriate policies and guidance. We were informed that FGM training is included in level two safeguarding training for registered professionals, however this does not give us assurance that this is sufficient to ensure practitioners are fully knowledgeable and aware of this complex issue. (**Recommendation 1.5**).

- 3.12 Risk assessments are carried out on all young people attending CASH services to identify vulnerability. We saw good identification and follow up of concerns by CASH and appropriate escalation and referral to children's social care. CASH's risk assessment used to identify potential safeguarding concerns, including CSE, is called The Spotting the Signs tool. While it asks where the young person spends time with their sexual partner and where they met the partner, it does not prompt the practitioner to record the partner's details. The LSCB CSE initial screening tool and assessment tool does not currently require the practitioner to record the partner's details or the location of the sexual activity. This is important detail to record as it can highlight multiple perpetrators and locations of CSE. The risk assessment is not routinely carried out on any subsequent attendance and therefore there is the potential for emerging vulnerability to be missed. ***This issue has been drawn to the attention of Somerset County Council which commissions the service.***
- 3.13 Other than significant problems with the way referrals are made into the multi-agency safeguarding hub (MASH) addressed elsewhere in this report, health's arrangements and well-resourced engagement with the MASH through Somerset Partnership NHS Foundation Trust's safeguarding team are working well. The Sompar team operate on a rotational basis such that each named nurse is based in the MASH for a month, every three months. We observed good multi-agency working within the MASH at this stage of its development. Observation of the daily multi-agency discussion of a number of cases demonstrated that the information gathering and prompt discussions are facilitating optimum decision making and agencies can respond to need quickly. It was clear that all agencies involved in the MASH currently are keen to develop the model based on best practice elsewhere and are open to learning in partnership across agencies.
- 3.14 Health visitors and school nurses use a standard report template when preparing reports for child protection conference and these are quality assured by the trust's safeguarding team. Health visitors and adult mental health prioritise attendance at child protection meetings and this is closely monitored by the trust. Due to capacity, school nurses only attend initial child protection case conferences (ICPC) as a matter of routine. The process of decision making about whether there is ongoing school nurse involvement in cases is not sufficiently rigorous and well evidenced.
- 3.15 All cases sampled in the school nurse service highlighted good multi-disciplinary and inter agency communication and liaison; with the school nurse acting as an effective bridge to link information about individual children between health and education.

- 3.16 Adult mental health is working towards establishing a Think Family model but there is a way to go before this is established as the operating model. Adult mental health practitioners do prioritise attendance at child protection conferences and this is closely monitored in the trust and we saw some good child protection practice. We saw little evidence of adult mental health, midwifery and health visitor joint visits or direct liaison between these services outside of formal child protection processes. Lack of effective communication and collaborative working between these services is a common feature of serious case reviews (SCRs).
- 3.17 Collaborative working is established between midwives and the adult substance misuse service in Yeovil, supported by bimonthly scheduled liaison as a multi-disciplinary discussion meeting. However, joint working and liaison for midwifery with adult mental health is under developed. However, we saw some case examples of highly effective liaison with other health professionals and the social worker by one adult mental health practitioner. This does not appear to be reflective of routine practice. There are no formal protocols in place between midwifery and adult mental health or substance misuse services to guide and support staff in working in as collaborative a way that best safeguards children and young people (**Recommendations 2.6**). ***This issue has also been drawn to the attention of Somerset County Council which commissions the substance misuse service.***
- 3.18 The integrated young people's and adults substance misuse service (SDAS) actively engages in child protection processes and we were told that they prioritise attendance at conferences. Documentation we saw in the service demonstrated that the impact of drugs and alcohol misuse on the client's capacity to parent effectively is considered. Additionally, practitioners encompass parent's drug and alcohol storage arrangements and other factors such as domestic abuse, violent behaviour and offending in their consideration of impact on the health and wellbeing of children. The service consistently uses the multi-agency referral form when making any referrals. The case we reviewed in the service evidenced an effective system for assessing young people who come into their service, particularly care leavers. Risks were properly documented and used to make decisions about the involvement of the service. We were told that there is effective communication between SDAS and other parts of the health economy particularly the maternity services, although there is scope to develop a stronger relationship with adult mental health.
- 3.19 At Yeovil Walk-in Centre, while attendance at child protection conferences is infrequent, reports are submitted routinely. These are prepared in a structured format in line with the local authority request by the patient's own GP.
- 3.20 Health services we visited reported good engagement with the multi/agency arrangements that focus on families where there are known domestic violence issues (MARAC).

- 3.21 We visited a small number of GP surgeries during this review. In one GP practice, we saw an example of a well-articulated risk assessment being provided to children's social care as part of a referral made by the GP for a family to access early help support. We also saw an example of GP attendance at a child protection conference. This was the named GP for Somerset who acknowledged that this is not typical practice across primary care. Overall, there is more to do to improve GP contribution to and participation in child protection conferences. We found little evidence that GPs were planning ahead and taking advantage of child protection conferences being scheduled well in advance, to ensure they could participate. The use of technologies such as teleconferencing or Skype has not been explored. A standard template for GPs child protection conference reports is available but there is no monitoring of who is using this at present (**Recommendation 6.2**).
- 3.22 GP practices we visited had robust arrangements in place to ensure all ED notifications were reviewed however we did not see processes in place to check and follow-up if children subject to child protection plans did not attend or were not brought to surgery appointments. (**Recommendation 6.2**).
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4. Looked after children

- 4.1 Most children coming into care in Somerset can expect to have their health needs assessed in a timely way and overall, there has been clear improvement in the service since the joint Ofsted/CQC inspection in 2012.
- 4.2 Children and young people are being given choices about where they have their health assessed and we could see evidence of the child as an individual in most initial health assessments (IHAs) and review health assessments (RHAs) although this could be stronger. We did not see children quoted directly for example, to ensure their voice was heard (**Recommendation 5.5**).
- 4.3 The quality of IHAs undertaken by paediatricians is variable and some we reviewed were poor with little or no evidence that this had been subject to any quality assurance and challenge. There is scope to improve the quality of the IHAs undertaken by the specialist nurse. IHAs for unaccompanied asylum seeking children are currently rarely required but must be undertaken by a paediatrician rather than the specialist nurse (**Recommendation 5.6**).
- 4.4 Health plans are in place for children who are looked after (CLA) across the service. They are not routinely sufficiently SMART, however. Plans are mainly task focused with loose timescales and professional accountabilities are sometimes unclear. (**Recommendation 5.6**).

- 4.5 The CLA health team were using the discharge summaries of babies discharged from Musgrove Park Hospital into the care of the local authority, as initial health assessments. The discharge summaries from the neonatal ward do contain pertinent information and can usefully inform health plans. However, the information from post natal discharge is insufficient for this purpose (**Recommendation 4.2 and 5.7**).
- 4.6 In the majority of cases sampled there was no record of the reason for the child becoming looked after and most lacked birth and parental health history. The absence of this information can have a lifelong impact upon the child's journey through placement into adulthood (**Recommendation 5.8**).
- 4.7 Consent forms completed by parents are on the children's social care database where they have been scanned in as part of the CLA process. This information is not being routinely transferred or referenced in the health assessment and review documentation to show the clinician that consent has been obtained. No evidence was seen of parent(s) being present at health assessments even when the child was accommodated under section 20 arrangements. This is a missed opportunity to seek or confirm consent and also to gather essential family history (**Recommendation 5.8**).
- 4.8 In all cases we reviewed, children's immunisations were up to date or had been picked up in a timely manner and swiftly brought up to date. We saw evidence that sibling records are individualised and records demonstrate the needs of each individual child have been considered separately. This is good practice.
- 4.9 The CLA health team are not well joined up with GP's. GP's are not routinely asked for information to contribute to RHAs for children although this is part of the service specification. More could be done to ensure that CAMHS inform RHAs routinely when they are engaged with the child. There is every facility in place for this as the services share an IT system and CAMHS are routinely contributing to and/or attending children's statutory reviews (**Recommendation 5.9**).

Case example: *A mother who was a known drug-user died suddenly and her children were taken into care. The mother had been well known to the GP because of previous drug use and the GP had good knowledge of the children. The GP had previously raised concerns about the mother.*

The children became looked after initial health assessments (IHAs) were appropriately undertaken by a paediatrician. However, no information about their health needs was requested from the GP who received an outcome notification of the assessment.

This was a missed opportunity to obtain health information from the GP about the children and family history which was likely to be highly important to the children in the future as they become adults.

- 4.10 Care leavers who are pregnant are not always identified in midwifery services as part of the vulnerable expectant women's criteria for additional support; only if they are under 19 and then only as part of the teenage pregnancy pathway rather than being identified as being additionally vulnerable by virtue of having been looked after. This is a missed opportunity to identify and support this highly vulnerable cohort of young women (**Recommendation 2.7**).
- 4.11 The health offer to care leavers remains under developed. Although work is in hand to put health passports/histories in place with the participation of young people, progress on this area since 2012 has been slow (**Recommendation 5.10**).

Management

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

5.1 Leadership and management

- 5.1.1 At the time of this CLAS review, Somerset County Council was not prescriptive in how agencies made safeguarding and child protection referrals. A referral template was available to all agencies but referrers could opt not to use it and most did not. The local authority's flexibility in how it received referrals, coupled with the lack of a consistent approach across and within the individual health trusts, served to compound the area for development. This approach did not support health practitioners in making the best quality referrals that would facilitate optimum decision making in children's social care. Neither did it facilitate effective quality assurance by operational managers within the provider organisations to support practitioner professional development and drive continuous improvement. Given the well documented fragility of child protection arrangements in the county, as identified in recent Ofsted inspections and acknowledged by the newly appointed director of children's services, this needed urgent attention from the CCG, Somerset County Council and senior managers in the provider services (**Recommendation 7.1**).
- 5.1.2 Investment in the development of a specialist looked-after children's health team provided by the partnership trust with clear leadership by the specialist looked-after children's nurse has been instrumental in improving health provision for children and young people who are in the care of the local authority.

- 5.1.3 The creation of the specialist team ensures a focus on the health of looked-after children which had not been there previously. There is significantly improved performance in the timeliness of initial and review health assessments. Co-location of the looked-after children's health team with children's social care recently is a very positive step towards developing a whole system approach. This is not yet established, however. There is more to do to ensure quality assurance processes in the service are robust. CCG governance and oversight of the unconventional operating model and service specification is also not sufficiently robust (**Recommendation 5.11**).
- 5.1.4 There is not sufficient capacity in the combined role of designated nurse for safeguarding and children looked-after. The post holder works hard, is very well regarded and seen as a valuable and accessible resource across all services including primary care. However, inevitably and rightly, her attention is primarily focused on the challenging safeguarding agenda. As a result, governance of and support to the CLA service is not robust. CQC's children's service inspection commonly sees CCGs investing in a separation of the designated nurse roles. This ensures an effective focus on these areas which nationally have grown in complexity exponentially over the past few years. Given both this national challenge and the significant local challenges faced by the children's social care and health partnership in Somerset, the current arrangement is hard for the CCG to justify (**Recommendation 8.1**).
- 5.1.5 At the time of this inspection, the designated doctor for children looked-after had been quite recently appointed and substantive arrangements were not yet in place for this role.
- 5.1.6 The named GP is developing his leadership role well and is developing whole county systems for primary care. While he was attending the LSCB and health sub group regularly, this has proved difficult due to a timing conflict with his salaried GP work and we understand that solutions are being worked on. We were told that the health sub group is operating as an effective forum for views from primary care to be heard. Most GPs seek advice and guidance on safeguarding issues routinely from the designated nurse.
- 5.1.7 The CSE Operational Group provides a useful opportunity to share information and provide direction, advice and support to practitioners who have referred the most vulnerable young people to the CSE group. The named nurse from SomPar is a valued member of the group providing appropriate challenge and support. Health representation on the CSE Operational group does not sufficiently represent or include primary care or acute services. Current arrangements are for the named nurse to attend and represent health, however, she can only provide information from her trust's services. We observed how there were significant gaps in information from primary care and acute services which would have usefully informed discussion (**Recommendation 6.3**).

- 5.1.8 The safeguarding team in Somerset Partnership NHS Foundation Trust (Sompar) is well led by the head of safeguarding and practitioners across the trust are well supported by a knowledgeable and accessible team. The increase in safeguarding resource for the CAMHs safeguarding lead professional is very positive. The purchase of an upgraded electronic recording system to help drive implementation of the Think Family model in adult services that the head of safeguarding is committed to is also very positive. Other assessment documentation and the training policy currently used in the trust is not effective in helping to drive the Think Family model however (**Recommendation 5.12**).
- 5.1.9 There is not sufficient capacity for the named nurse role at YDHT and there is a need for succession planning for when the post holder retires. The named nurse provides high levels of valued support to practitioners, particularly in midwifery; accompanying practitioners to strategy meetings, ICPCs and discharge planning meetings if deemed necessary. However, the post holder has limited opportunity for continual professional development or auditing safeguarding practice due to her role as named nurse for the entire hospital trust. We understand that additional support to the role has been agreed very recently and this may help to facilitate the necessary introduction and establishment of stronger governance arrangements.
- 5.1.10 CQC's inspection of the Musgrove Park Hospital in September and October 2013 raised issues about the suitability of equipment and ante natal and post natal facilities that needed refurbishment. We also found these to be of poor quality; not reflective of healthcare facilities in which expectant women and new parents and their babies might want to receive care. Toilets and shower facilities are all shared on a separate corridor and individual patient areas are only separated by paper curtains. Whilst nursing staff try their best to maintain the privacy and dignity of women, our view was that this is impossible in this environment (**Recommendation 4.3**).
- 5.1.11 The partnership trust safeguarding team are familiar with the local LSCB protocol on resolving professional disagreement and this is well used. However, from information given it appears that there continues to be many cases escalated to a senior level because of the failure to identify and resolve concerns at operational level. We understand that to date, the effectiveness of the escalation policy and how practitioners raise professional dissent issues has not been audited or evaluated by the LSCB.
- 5.1.12 At Yeovil Walk-in Centre, we found a robust records management system that captures safeguarding information in sufficient detail to enable effective decision making about children subject of a child protection plan, looked after or with any other concerns. All staff working in the practice have access to the same information. Child protection conference minutes and other documentation from children's social care is managed effectively and accessible to practice staff.

- 5.1.13 Paediatric liaison in the ED at Musgrove Park Hospital is limited by the capacity of the trust's paediatric liaison nurse. Current arrangements are that only those attendances by infants under one are routinely reviewed by the liaison nurse and there is a reliance on ED practitioners identifying need and recording it in the "diary". There is no other opportunity for attendances of children and young people over one to be reviewed to ensure that any safeguarding or child protection concerns have not been missed (**Recommendation 4.4**).
- 5.1.14 Opportunities to meet and improve safeguarding practice within the ED at Musgrove Park Hospital are limited. There is no single multi-disciplinary, multi-agency forum to review cases of concern within the ED and to share learning from good practice. Where we have seen these forums established in other areas, these are facilitating early identification of need and effective multi-agency response (**Recommendation 4.5**).
- 5.1.15 There are capacity pressures on the safeguarding team for Taunton and Somerset Foundation Trust as a result of the lack of administrative support, combined Head of Midwifery/named midwife role and limited capacity for paediatric liaison. We note the increase in safeguarding liaison nurse from 0.4 to 0.6 whole time equivalent (WTE) and the recent recruitment of a lead midwife for safeguarding. Whereas all anaesthetists have undergone bespoke safeguarding training and there is an anaesthetic child protection policy/guidance in place; the trust does not have a named lead anaesthetist for child protection as recommended by the Royal College (**Recommendation 4.6**).
- 5.1.16 In primary care, we saw some good "flagging" on patient records systems to alert practice staff to concerns about children on CIN and child protection plans and families where there was known domestic violence. Practice on "flagging" and coding on systems was mixed however and another practice did not code for these risk factors. Not all GPs visited were linking parental difficulties such as drugs and alcohol, mental health or domestic violence to children's records. As a result, children who are vulnerable to significant risk of hidden harm may not be identified and practitioners not be alerted to potential risk and this is a significant gap. The named GP is developing whole county systems to improve primary care safeguarding practice. However, there is some work to do to ensure consistency of use and effective governance (**Recommendation 6.4**).

- 5.1.17 Young Healthwatch raised concerns with us about the provision for young people with emotional health problems and developing mental illness. Young Healthwatch told us of their perception that CAMHS thresholds seem to be raised higher and higher, and there is very limited early help for young people. They gave us examples where, because of the lack of early help support to individual young people their needs have escalated, to the point where they have eventually been admitted to specialist units following attempted suicide. We saw case examples which illustrated this. Commissioners and the trust are acutely aware of the need to improve access to CAMHS and are working together to improve capacity and access.
- 5.1.18 The school nurse service was exploring new ways of delivering the NCMP programme using Band 4 staff, in order to release school nurse staff to undertake other duties.
- 5.1.19 Due to capacity pressures, school nurses attend ICPCs only, making a decision from that meeting on whether or not they need to be involved. There is no process currently to complete a health assessment and use this as a benchmarking and decision making tool for further involvement in child protection cases. Practitioners acknowledged this would be useful to further evidence and strengthen their decision making rationale, particularly when they are stepping down from the case and will not be attending further child protection meetings. ***This issue has been drawn to the attention of Somerset County Council which commissions the school nurse service.***
- 5.1.20 The school nurse best practice group which includes all grades of staff and administrators meets monthly to share good practice ideas and resources to ensure consistency in service delivery across Somerset. This is a very positive development, facilitating continuous practice and service improvement.

5.2 Governance

- 5.2.1 Governance arrangements monitoring the effectiveness of providers' safeguarding service delivery have been strengthened under the CCG but are not yet sufficiently rigorous to ensure consistency or best safeguarding practice across the health economy. There was a worrying absence of any effective governance arrangements within health services to ensure that appropriate safeguarding referrals are made and that they are of sufficient good quality to help children's social care make effective decisions about what action to take. We saw many examples of very poor practice in recording referrals and ensuring effective audit trails or evidence of ownership of professional accountability. It was not clear that CCG governance had identified this gap and was taking action to ensure effective governance was in place across and within provider services (**Recommendation 7.2 and 8.2**).
- 5.2.2 We found a lack of professional curiosity among practitioners across frontline services when risk indicators that were evident in cases involving children should have prompted practitioners to question and probe situations further. This was of concern. Inspectors saw too many case examples during this review where health practitioners had been passive recipients of information rather than considering and evaluating whether it made logical or contextual sense. In part, this is a training issue. However, it is beholden on operational managers to ensure there are effective governance arrangements in place to drive consistent good practice in the service and continued professional development for staff, monitored through robust supervision (**Recommendation 7.3**).
- 5.2.3 In YDHT, the Acorn midwifery team provide an annual report for the maternity risk management meeting. This demonstrates good governance processes.
- 5.2.4 Taunton and Somerset Foundation Trust midwives understand that they should prioritise attendance at child protection meetings and the safeguarding lead midwife has recently introduced a mechanism to monitor and report attendance. The trust does not currently require this reporting as part of the safeguarding dashboard despite it being a key indicator of activity.

- 5.2.5 Good practice seen in YDHT midwifery was based on strong individual practitioners rather than being underpinned by organisational processes or departmental systems which support co-ordinated or outcome driven working. Discussion with different midwives and the cases sampled indicated that cases with similar risks are handled differently by different practitioners. Child protection reports are not routinely filed in records, leading to the risk that midwives cannot ensure compliance with the plan to deliver the best outcome for unborns and new born infants. Lack of clear systems and processes also inhibit operational managers' ability to monitor practice standards effectively.
- 5.2.6 Child protection paperwork, including any child protection plan, is not currently held on the Musgrove Hospital midwifery record. This means that the record is incomplete and is poor practice. Health practitioners working with children or infants subject to child protection plans need to have immediate access to that plan as part of the case record. This not only supports the practitioner to practice effectively in safeguarding the child but also facilitates effective practice governance by operational managers (**Recommendation 4.7**).
- 5.2.7 The review of all u18 presentations in the paediatric ED at Yeovil by the safeguarding named nurse is an effective backstop to ensure any safeguarding issues are picked up and to communicate attendances with community staff. There are particularly robust measures in place for under 5's.
- 5.2.8 There is more to do across the interface between acute services in the hospital trusts, primary care in the MIUs and school nurses to ensure that the exchange of information between the services is effective in ensuring community support is targeted and needs are followed up appropriately. School nurses reported that the information or notification form they receive after an individual's attendance at ED and MIU is not sufficiently useful in assisting the service to prioritise work. We were told that notifications often contain scant details around adult attendances where there are children at home. Practitioners and managers told us that commonly, no children's details have been taken and there is little information about the nature of any parental risk taking behaviour. This makes follow up by school nursing a difficult and time consuming task in a service where capacity is very pressured (**Recommendation 3.6**). ***This issue has been drawn to the attention of Somerset County Council which commissions the school nurse service.***
- 5.2.9 There is good operational oversight in the Somerset Partnership NHS Foundation Trust school nurse service to ensure the quality of information contained in child protection conference reports is of a high standard. A standard template is used for child protection conference reports and all are checked by a safeguarding supervisor prior to submission. Practitioner attendance and report submission is recorded and audited quarterly by the team leader and this is good governance.

- 5.2.10 Somerset Partnership NHS Foundation Trust school nurse electronic record keeping and care planning in cases sampled was thorough and comprehensive, with an emphasis on analysis and liaison in both a multi-disciplinary and multi-agency way. This has clear benefits in promoting effective information sharing with other community professionals.
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5.3 Training and supervision

- 5.3.1 Across Somerset there is a trend of under-identification and reporting on health professionals, including those in adult services, whose job roles meet the criteria for requiring Level 3 safeguarding training. The intercollegiate guidance is clear that practitioners working with children and young people and families with children should receive training at Level 3. Training at level three should include a multi-agency component in line with statutory guidance and best practice.
- 5.3.2 Along with other providers, safeguarding training within the Somerset and Taunton NHS Foundation Trust is underdeveloped. Response to the intercollegiate guidance on the need to identify and ensure practitioners who work predominantly with children and young people are appropriately trained has not been timely and the trust is only now working to develop a syllabus to support implementation of Level 3 training. Key groups of staff who work with vulnerable and complex families therefore, are not appropriately trained. To date the training syllabus has not been endorsed by the LSCB.
- 5.3.3 Adult mental health practitioners are not trained to level 3 in children's safeguarding. This is not compliant with the trust's own policy, statutory and intercollegiate guidance and is not sufficient in supporting practitioners in their everyday practice (**Recommendation 7.4**).
- 5.3.4 School nurses told us they valued attending the LSCB training highly as it had positively impacted on their safeguarding practice particularly with hard to engage families. Practitioners felt however, that in-house training did not meet their training needs sufficiently as it was not detailed or updated enough to reflect their experience. ***This issue has been drawn to the attention of Somerset County Council which is the commissioner of the school nurse service.***
- 5.3.5 Arrangements are in place for safeguarding lead GP's to access additional training on an annual basis. Level 3 training arrangements are currently under developed consisting of 3 hours face to face every 3 years. This deficit has already been acknowledged by NHS England and the CCG and new plans are in place to make this more robust, linked to the appraisal process and to include practice reflection.

- 5.3.6 CASH practitioners are trained to Level 3 safeguarding and evidence seen from risk assessments and notes of consultation show good understanding of the risk of CSE. We were told that practitioners access regular supervision and that reference to this is recorded on a patient's electronic record.
- 5.3.7 Supervision of safeguarding children practice within Taunton and Somerset Foundation Trust midwifery is improving; monitoring arrangements for compliance are now in place. Midwives in YDHT have access to ad hoc support and supervision for safeguarding from the named nurse and formal scheduled supervision is in place for all teams. YDHT midwives in the Acorn team working with vulnerable women have enhanced supervision on a monthly basis. However, midwifery practitioners in both YDHT and TSFT do not routinely log supervision and record outcomes from these discussions on the woman's patient record in line with best practice (**Recommendations 1.6 and 4.8**).
- 5.3.8 Newly qualified Sompar health visitors are well supported by a robust preceptorship programme with competency based assessment for safeguarding and child protection. The current preceptorship in the Taunton and Somerset Foundation Trust midwifery service is not competency based and is over-reliant on mandatory training (**Recommendation 4.9**).
- 5.3.9 School nurses have good access to both scheduled and ad hoc 1:1 safeguarding supervision. One to one supervision for band 6 practitioners is every 3 months in line with good practice. Supervision notes are kept in the child's records and in cases we sampled, onward planning and actions were clear.

Recommendations

- 1. Somerset CCG and Yeovil District Hospital NHS Foundation Trust should:**
 - 1.1 Ensure that ante natal home visits are undertaken in line with best practice and to strengthen pre-birth risk assessment
 - 1.2 Ensure that midwives complete and update risk identification forms as required and share this information with other professionals involved with the family, in a timely way
 - 1.3 Ensure provision of specialist midwifery expertise in order that expectant mothers with mental health needs are well supported
 - 1.4 Ensure that paediatric ward staff are supported to care for young people admitted with mental health needs through the provision of appropriate mental health training
 - 1.5 Ensure that a policy is in place across the trust to address risk and incidences of female genital mutilation
 - 1.6 Ensure that midwives log supervision and record any resulting decisions or outcomes on the expectant woman's patient record in line with best practice

- 2. Somerset CCG, Yeovil District Hospital NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust should:**
 - 2.1 Ensure that initial booking information includes questions about paternal health and lifestyle choices that may have an impact on the unborn or newborn infant
 - 2.2 Ensure that expectant mothers are routinely seen alone to facilitate disclosure of domestic violence or other risk factors
 - 2.3 Ensure that risk assessment for vulnerability is repeated during pregnancy to identify changes in risk levels or emerging concerns
 - 2.4 Put in place electronic flagging systems to support effective safeguarding risk assessment in hospital emergency departments
 - 2.5 Work with Somerset County Council to ensure that pre-birth child protection processes and practice are operating effectively in line with the agreed pre-birth protocol

- 2.6 Ensure that inter-service collaboration and routine liaison between practitioners working with the same children and/or family becomes established practice
- 2.7 Ensure that the additional vulnerability of care leavers who become pregnant is identified and supported in midwifery services

3. Somerset CCG, Yeovil District Hospital NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust should:

- 3.1 Develop effective information sharing protocols between midwifery and primary care
- 3.2 Ensure that ED risk assessment documentation encompasses the potential for hidden harm to best support clinicians in their assessment of any safeguarding concerns
- 3.3 Work with Somerset County Council to develop an effective young people's substance misuse referral pathway for the ED in order that appropriate early support can be offered to young people
- 3.4 Ensure that environmental risks are addressed when young people at risk of serious self-harm are admitted to paediatric wards
- 3.5 Ensure that use of chronologies is routine practice in midwifery services
- 3.6 Work in partnership with the school nurse service to strengthen the ED and MIU notification pathway between acute settings and community based services

4. Somerset CCG and Taunton and Somerset NHS Foundation Trust should:

- 4.1 Put in place appropriate paediatric safeguarding triage documentation, separate from that used for adult patients and ensure all protocols in place accord with NICE recommendations and guidance
- 4.2 Ensure that where infants are taken into local authority care on discharge from hospital, appropriate assessment documentation is completed in order that health needs are comprehensively assessed
- 4.3 Ensure that appropriate ante natal and post natal facilities are provided in line with the Trust's aims to provide high quality, modern healthcare
- 4.4 Ensure that there is effective review and oversight of all children and young people who attend the ED in order that any safeguarding or child protection concerns have been identified and acted on.

- 4.5 Establish a multi-disciplinary, multi-agency forum to review cases of concern within the ED and to share learning from good practice
- 4.6 Ensure sufficient capacity in the Trust's safeguarding team and that safeguarding roles are in place in line with national guidance.
- 4.7 Ensure that child protection documentation is included in the midwifery case record to support best safeguarding practice and effective governance by operational managers
- 4.8 Ensure that midwives log supervision and record any resulting decisions or outcomes on the expectant woman's patient record in line with best practice
- 4.9 Ensure that preceptorship programmes for newly qualified practitioners are competency based in line with best practice

5. Somerset CCG and Somerset Partnership NHS Foundation Trust should:

- 5.1 Work with Somerset County Council to develop an effective young people's substance misuse referral pathway with the hospital EDs in order that appropriate early support can be offered to young people
- 5.2 Develop a perinatal mental health service in line with national guidance
- 5.3 Ensure that care plans in CAMHS are developed with the full participation of young people and to a consistent standard
- 5.4 Ensure that the CAMHS service continues to develop the service in a way that is informed by the young people's participation group as part of its governance and quality assurance processes.
- 5.5 Strengthen the voice of the child in initial and review health assessments of children and young people who are looked after
- 5.6 Ensure that initial health assessments, review health assessments and health plans for children and young people who are looked after are subject to quality assurance that is effective in improving quality and consistency
- 5.7 Ensure that where infants are taken into local authority care on discharge from hospital, appropriate assessment documentation is completed in order that health needs are comprehensively assessed
- 5.8 Work with Somerset County Council to ensure that the reason for the care episode, parental consent and parental health history information is routinely transferred and included in initial and review health assessment as part of the looked after child health documentation

- 5.9 Work with GPs to ensure that CAMHS and primary care are routinely contributing to initial and review health assessments for looked-after children and young people
- 5.10 Work with young people to ensure the development and provision of comprehensive health histories and age appropriate, personalised public health information in order that care leavers are supported well by health as they become adults
- 5.11 Ensure the service model and specification for the delivery of health support to children and young people who are looked after is robust and subject to effective governance and quality assurance
- 5.12 Ensure that the trust's assessment documentation and training policy support the establishment of an effective Think Family delivery model in adult services effectively
- 5.13 Ensure that use of chronologies is routine practice in health visitor services

6. Somerset CCG and NHS England should:

- 6.1 Work with primary care to ensure that multi-disciplinary vulnerable families meetings routinely take place in GP practices
- 6.2 Work with primary care to strengthen safeguarding governance across GP practices to promote continuous improvement
- 6.3 Work with Somerset County Council, Police and all providers to ensure that arrangements for health representation and information sharing at the CSE Operational Group best supports prompt and optimum decision making to protect children and young people
- 6.4 Work with primary care to ensure consistent use of "flags" on patient records to identify known risks to children and the potential risks of hidden harm

7. NHS England and Somerset CCG working in partnership with Somerset County Council; and Yeovil District Hospital NHS Foundation Trust, Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust should:

- 7.1 Put in place a single health provider safeguarding referral pathway to the MASH, subject to effective governance and quality assurance
- 7.2 Ensure that effective quality assurance and governance arrangements are in place in relation to referrals to the MASH and children's social care

- 7.3 Put in place effective governance arrangements to monitor the delivery of continuously improving safeguarding practice in frontline services, including primary care
- 7.4 Ensure that all health practitioners undertake safeguarding training at a level commensurate with their roles and responsibilities and multi-agency at level 3, in line with inter collegiate guidance and subject to effective monitoring

8. Somerset CCG should:

- 8.1 Ensure the arrangements for the Designated Nurse role(s) for safeguarding and CLA are appropriate to deliver identified improvements and to undertake effective governance in both areas
- 8.2 Strengthen safeguarding governance arrangements in order to ensure continuous improvement in safeguarding practice across the health community

Next steps

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

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