

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

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

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Provider services included:	<p>Looked After Children's Nurses are provided by Dorset Healthcare University NHS Foundation Trust.</p> <p>Acute hospital services are provided by Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.</p> <p>Health visitor and school nursing services are provided by Dorset HealthCare University NHS Foundation Trust.</p> <p>Contraception and sexual health services are provided by Dorset HealthCare University NHS Foundation Trust, acting as lead provider for the consortium of providers known as Sexual Health Dorset.</p> <p>Child substance misuse services are provided by Addaction.</p> <p>Adult substance misuse services are provided by Addaction and Avon & Wiltshire Mental Health Partnership NHS Trust.</p> <p>Child and Adolescent Mental Health Services (CAMHs) are provided by Dorset HealthCare University NHS Foundation Trust.</p>
CCGs included:	NHS Dorset Clinical Commissioning Group
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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 Bournemouth. 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 Bournemouth, 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 2012 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 2018.
- 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 63 children and young people.

Context of the review

The 2017 Child and Maternal Health Observatory (ChiMat) profile provides a snapshot of child health in Bournemouth.

Children and young people under the age of 20 years make up 21.0% of the population of Bournemouth with 25.4% of school age children being from an ethnic minority group. On the whole, the health and wellbeing of children in Bournemouth is mixed compared with the England average. For example; in 2017 looked after children immunisations stood at 90.2% compared to an England average of 84.6%. First time entrants to the youth justice system stood at 414.2 per 100,000 compared to the England average of 292.5 per 100,000. Looked after children numbers stood at 67 per 10,000 compared to an England average of 62 per 10,000. And 2016/17 figures for hospital admissions for mental health conditions stood at 118.2 per 100,000 compared to the England average of 81.5 per 100,000.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Bournemouth. The most recent (2017) average SDQ score of 14.9 is slightly above the England average of 14.1 for the same year.

The DfE reported that Bournemouth had 173 looked after children that had been continuously looked after for at least 12 months as at 31 March 2017 (excluding those children in respite care).

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 spoke with a looked after child that was also accessing CAMH services. They told us:

"I have my health assessment every year although I have no health problems. I don't mind though because they (the looked after children nurses) are nice and involve me and listen to what I have to say."

She went on to say:

"I was overweight and I had very low self-esteem. But since I have been seeing my looked after nurse these last years she has set me goals and given me the confidence to lose weight and I feel much better about myself now. I'm doing well at school and I am seeing CAMHs every week. I'm doing OK and that's good. CAMHs also set me goals and help me reach them. I don't think anything could be improved. I was seen really quickly."

We spoke with foster carers in Bournemouth. One we spoke with told us:

"The looked after nurse gives me advice. They have really helped me with my foster child when he had health issues. They helped me get on the website to get the information I need. The nurse helped me get an appointment brought forward too."

When asked about access to services and equipment the same foster carer told us:

"I was trying to find someone to get me incontinence pads for my child. Sometimes the nurses can't help. I found that difficult. I pursued this in end, but the nurse helped me by telling me who I should speak to."

They went on to tell us:

"I can't say anything negative about the nurses. But I did have to raise a concern about the GP when they did an examination on one of my children and tried to undertake a procedure which I did not think was age appropriate. The looked after children's nurse took this on for me and they sorted it out."

We asked a foster carer how accessible health services were to them and their foster children. One we spoke with told us:

“My child is disabled and their health needs are high and quite specialist. Because of their specialist care they need their consultant is based Southampton. It’s a 28-mile journey, so about 45 minutes travel. It can be challenging. Sometimes we get an early appointment and we have had to fight to get the appointment later in the day. We reorganise all the appointments, it’s quite a process to go through, but it’s all sorted now.”

We asked foster carers how involved they were in the health assessment process. One we spoke with told us:

“We are fully involved in health assessments and they listen to what we have to say. Bournemouth are the only local authority that listen to the foster parent compared to others. They always say ‘you know him better than we do.’ They are very good. It’s quite nice they respect our views.”

We spoke with the parent of a child who had been referred to the Poole Hospital ED. They told us:

“We are supported by a social worker but questions about that here seem like a ‘tick-box’ exercise. Nobody has asked me if all the support we require is actually in place.”

We spoke with a young person who had attended a ‘drop in’ session and the Addaction substance misuse service in Bournemouth. They were supported by a parent. The young person told us:

“I came here because of my long-time abuse of weed (cannabis) that I want to give up. I’ve had my first meeting and it was good. I have anxiety but he (the care co-ordinator) put me at ease. It was alright. He said that I could get support with my habit and they would set goals for me and all that. He asked me lots of questions, including some about my safety. I’m glad I came today.”

We spoke with the young person’s parent who told us:

“It’s good to know you can go somewhere where people don’t judge you. I’m glad there is a chance here.”

We spoke with a parent of a young person who had been the subject of child sexual abuse. When asked about what support was available to support and meet the needs of the young person they told us:

“It’s been incredibly difficult to find support in our local area. I found a charity that has helped us a lot but it is not well known and I’m aware that others who could need the same support might not be aware of it. Also, the charity might run out of money soon so who will be there to support us all then?”

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 Health practitioners at the Multi Agency Safeguarding Hub (MASH) are provided by Dorset Healthcare University NHS Foundation Trust (DHC). Referrals made by multi-disciplinary health practitioners across Bournemouth are first received by the social care 'front door' team where a decision is made as to whether the referral meets the threshold for forwarding to the MASH for strategy discussion and decision making. We were told by health practitioners within the MASH that they receive a precis of the referral written by the social care 'front door' team and do not have sight of the original document. However, we have since been advised that they can have sight of the original referral document where one is available and sight of referral notes if that referral is made verbally but this information was not made available to us at the time of our review. There is risk therefore, that in not having sight of the original referral, then important information which a trained health practitioner might recognise could be lost and not go on to inform the decision-making process so that support can be provided at the earliest opportunity.

Recommendation: 4.1

1.2 When a health practitioner makes a referral to children's social care regarding safeguarding concerns, they will be notified of the decision only if the referral meets the threshold for strategy discussion at the MASH. Should a referral be considered at the 'front door' as not meeting that threshold, then those practitioners making referrals should be informed by children's social care of the outcome. However, in records examined and in discussion with practitioners we saw that this does not always happen. This means that those practitioners will not be aware if the referral had been considered or if they should be adapting their interactions with potentially vulnerable children and young people to better protect those at the periphery of care. Further, if a practitioner is not made aware of the outcome of their referral they might not be in a position to challenge the decision.

Recommendation: 4.2

1.3 Health practitioners at the MASH have access to a number of electronic patient record systems, including those for both adult and Child and Adolescent Mental Health services (CAMHs) and sexual health services. However, access to 'SystmOne' primary care records, health visiting and school nurse records is via 'read only' access. This means that MASH practitioners cannot 'task' those services or attach records such as strategic meeting decision making documents. In one record examined we saw that, although a precis of the strategic meeting outcome was recorded in the patient's contacts log, the original strategy discussion and outcome document was not attached some six weeks following on from the discussion and decisions being made. This means that the young person's electronic record remains incomplete and support measures were not recorded.

Recommendation: 4.4

1.4 The strategy discussion document used by health practitioners within health at the MASH, uses the 'signs of safety' model (a strengths-based, safety-organised approach to child protection casework). This means that not only are the identified risks to children included in the decision-making process, but also any protective factors that can be considered to better protect vulnerable children and young people.

1.5 Leaders from Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBCH FT) and the Poole Hospital NHS Foundation Trust (PHFT) have worked together to create shared safeguarding assessment paperwork. Both trusts also make use of the same Child Sexual Exploitation (CSE) risk assessment tool which promotes consistency across the local area. This ensures that practitioners are applying the same thresholds when assessing potential risk to children and young people who require acute input. However, in records examined at the Poole Hospital Emergency Department (ED) we saw that the use of assessment tools was variable and did not always identify risk well. This means that those children and young people from Bournemouth who elect to attend that ED or are sent there from the Royal Bournemouth hospital, are not always assessed for risk of CSE appropriately. **Recommendation: 5.1**

1.6 Bournemouth children and young people entering the PHFT ED at Poole Hospital do not benefit from a separate provision to adults who also present at the ED. There is a lack of physical, appropriate space dedicated to children and young people and the single paediatric nurse present on all shifts is not used exclusively for children despite the high number of children accessing the ED. Given that the paediatric wards at Poole Hospital do not accept children over the age of 16 (unless previously known to them), there are limited measures in place to ensure the safety of 16 to 18-year-old young people placed in adult wards, but also children accessing the ED who may be exposed to potentially risky adults in the communal areas.

Leaders recognise that this is an area for development and are hoping to improve with the introduction of additional paediatric staff and additional child only beds. However, the risk remains that Bournemouth children and young people who might otherwise elect to be seen within a paediatric environment, are being exposed to an adult environment which they might find distressing. **Recommendation: 3.1**

1.7 The specialist midwifery offer to women in Bournemouth with vulnerabilities that require additional intervention to ensure the risks to themselves and their unborn child are managed appropriately, is good. For example, the 'Sunshine Team' provide care and support to women who are recognised as having vulnerabilities regarding; mental health, substance misuse and be at risk of domestic abuse to ensure the risks to themselves and the unborn child are managed appropriately.

1.8 Midwives in Bournemouth, but also those Bournemouth women referred or electing to receive care at Poole Hospital, are not having vulnerabilities in relation to domestic abuse assessed and checked appropriately or in-line with national guidance. In records examined we saw that questions in relation to domestic abuse are not routinely asked throughout a woman's pregnancy. We were advised that midwives cannot always see women alone to ask about domestic abuse, but we could not evidence if alternate measures were being explored to provide opportunity to ask those important questions. In most cases examined we saw that if questions regarding domestic abuse are being asked, then it is at the booking stage and not at other stages of pregnancy.

This is a missed opportunity to engage with pregnant women during their pregnancy at a time when statistically, they are most vulnerable to domestic abuse.

Recommendation: 5.2

1.9 The DHC health visiting service, as part of the planned transfer to a 0 to 19 service model, has undergone significant change over the last 18 months. There has been a period of instability and staffing pressures within the service, but leaders report a high level of resilience and commitment by practitioners to continue to deliver the core service, exceeding targets for engagement with the full healthy child programme. This means that mothers and infants in the local area benefit from regular development checks and have good opportunity for any unmet needs or concerns to be identified.

1.10 GP surgeries across Bournemouth benefit from a health visitor linked to every surgery. Furthermore, multi-disciplinary GP lead safeguarding meetings are in place at GP practices to enable discussion and planning for children and families where there may be additional vulnerabilities. This means that concerns can be readily shared between health services and appropriate support can be put in place where required.

1.11 Health visitors are not regularly making routine enquiry into potential for abusive relationships between parents. There is an expectation that a mother is asked at the antenatal contact, where safe to do so. Whilst the health visiting statement of practice includes specific reference to enquiry into domestic abuse and violence both at the antenatal and new birth visit (other contacts refer to child safety), there are no prompts in place on SystemOne to record this beyond the antenatal contact. This means that mothers may not have good enough opportunity to disclose when they are in unhealthy or abusive relationships and disclosures may be missed. **Recommendation: 4.5.** *Public Health commissioners will also be notified of this finding.*

1.12 We found that, due to the current commissioning arrangements, the school nursing service is not always able to pro-actively promote good health and safeguarding practice to its client group.

Although the School Nursing integrated team delivers separate services, including immunisations and core public health services such as the National Child Measurement Programme (NCMP), during our review we were advised that there are no 'drop in' services within Bournemouth schools that children can attend to seek advice and guidance from linked school nurses. However, since we undertook our inspection we have been advised that there is a programme of drop-ins for all primary schools in Bournemouth, which is negotiated with schools and offered at least termly, although some schools decline the offer. Through the school health profile process, where levels of need for each school's population are identified, drop-ins can be arranged with senior schools to meet the individual school's particular pattern of needs.

We spoke with children and young people during our review and all of those we asked said that they did not know who their school nurse was. We also spoke with Specialist Public Health Community Nurses (SCPHNs) and they told us that they are not being utilised effectively to identify and meet the health needs of the school age population. Although we have been made aware of the school 'drop-in' service offer, we cannot be assured of the effectiveness of how such offers are audited as meeting the needs of children and young people in Bournemouth.

1.13 There is a reliance on a CHAT health text messaging system to allow contact between children and school nurses rather than having a highly visible presence in schools. Although the service has since been evidenced as an effective one evidence to support this was not provided at the time of the review which brings into question staff awareness of its usefulness and importance. The service is actively promoted via GP localities and the nursing webpage to help meet the needs of children whose school might not actively promote the service, such as faith schools. *Public Health commissioners will be notified of this finding.*

1.14 During our review we did not examine any examples of school nurse health assessments undertaken for vulnerable children (such as those who might be considered at risk of neglect) as these are not routinely conducted even where risk might be identified. This is a missed opportunity to identify need and risk and for the SCPHN make their unique contribution to the safeguarding process. This means the health needs of potentially vulnerable school age children are not routinely being assessed in Bournemouth. **Recommendation: 4.6.** *Public Health commissioners will also be notified of this finding.*

1.15 Home educated children are at risk of not having their health needs identified. We were told that the school nursing service would offer core interventions to a child if they were informed that the child was being home educated, but that the local authority does not routinely notify the service of children and young people who are educated at home. Therefore, this potentially vulnerable group of children can remain invisible to the school health service. *Public Health commissioners will be notified of this finding.*

1.16 Young people with emotional mental health needs are referred into the CAMH service through a single point of access. Referrals are screened daily during a multi-disciplinary screening meeting and are prioritised according to need. The CAMHs duty team action any referrals which require a same day response which means that those young people requiring urgent care and support have their needs met quickly. Referrals which do not meet the threshold for CAMHs are, where considered appropriate, routinely signposted to another relevant service identified able to provide care and support in a timely manner.

1.17 Children and young people are encouraged to contribute their wishes, thoughts and feelings at the point of referral into the CAMH service. There is a specific section on the referral form to capture this important detail. This means that the voice of the child is heard from the earliest contact with the CAMH service and children and young people can, where appropriate, inform the service offer provided to them.

1.18 Daily multi-disciplinary assessment discussions enable CAMHs practitioners to validate their assessment decisions with peer support and critique. This ensures that the needs of the most complex children and young people accessing the service are better understood and their needs are managed via the most appropriate pathway.

1.19 Dedicated CAMHs crisis workers provide good support to young people admitted to both the Bournemouth Hospital ED and Poole Hospital ED inside extended working hours. This means that those vulnerable children and young people will get their mental health needs met once their immediate medical needs have been attended to.

In one case examined, we saw how an older young person was admitted to an adult medical ward under section of the Mental Health Act. The young person was known to the CAMH service and their needs were well understood due to previous robust interventions of the multi-disciplinary CAMH team.

A diligent approach by the out of hours team led to an accurate assessment of the young person's changing needs. Practitioners were then able to overcome the young person's initial reluctance and engage with them effectively. CAMHs practitioners also advocated for the young person during their short stay in hospital whilst they recovered physically. This meant that, at the conclusion of the period under Mental Health Act section, the young person was sufficiently stable enabling plans to be made for their safe discharge from hospital.

1.20 The majority of clients accessing adult mental health services are held on a standard Care Programme Approach (CPA). Leaders informed us that these clients will only be seen by a doctor rather than benefit from more frequent contact with a mental health practitioner, such as those on an enhanced CPA. This reduced level of contact restricts the services' ability to have sight of clients, and any associated children for who they have carer or parental responsibilities. This in turn reduces the opportunity to identify safeguarding concerns within the family setting.

We have since been informed that there are two levels of care; people requiring medication review or with less complex needs will be seen by a Doctor in outpatients and if a safeguarding concern was indicated, a referral would be made to children's social care. People with more complex levels of need, e.g. psychosis, social problems, depot medication, poor engagement etc. will be seen by a care coordinator. However, at the time of the inspection, a reduced level of contact was indicated for those clients held on a standard care approach to pro-actively identify concern. **Recommendation: 4.7**

1.21 Contraception and Sexual Health services (CASH) are commissioned by Public Health Dorset on behalf of the three local boroughs (Bournemouth, Dorset and Poole) and provided by DHC. The service has a targeted outreach team to identify need and promote service provision by CASH services pan-Dorset, including Bournemouth. Practitioners will attend events across Bournemouth including; 'fresher' events, army camps, local colleges, universities, youth and community centres and nightclubs and public houses. By doing this, those practitioners promote their service offer so that young people can be better aware of risk taking behaviours and support available to meet their needs.

1.22 The CASH targeted outreach team have produced a training package available free to schools in Bournemouth for use in educating young people aged 11 years and over about sexual health and safe relationships. The 'BLITZ' package has been devised in conjunction with the young people's Addaction substance misuse service. The package can be utilised as the school decides over several lessons if required and supports teachers in its delivery.

Approximately 60 schools across Dorset, Poole and Bournemouth have signed up to the programme and CASH outreach workers are assigned schools who are utilising the package to provide ongoing support as required. This is good practice to educate young people in relation to safe sex and relationships in an environment in which they can feel safe with the support of their teachers. However, we heard that there are currently fewer schools accessing the package than in previous years although at the time of our review we were unaware of the reasons for this we have since been advised that this is due to schools now delivering the package themselves.

1.23 Both adolescent and adult alcohol and substance misuse services are provided by Addaction as commissioned by Bournemouth Borough Council with the prescribing service provided by Avon and Wiltshire Mental Health Partnership (AWP). On accessing either service, young people and adults are assessed using a drug use screening tool which fully explores the nature and type of substance misuse, but also other health and social issues. These then lead to a score of risk which aids the care coordinator undertaking the assessment to consider safeguarding measures as appropriate.

1.24 A representative from the Addaction young people's and families team attends multi-agency early help allocation meetings via the Bournemouth early help partnership on a regular basis to provide information, advice and support. They will also accept referrals into service via those meetings.

1.25 There has been good commissioning investment into the Youth Offending Service (YOS) health offer by the Dorset CCG with three band six nurses, one clinical psychologist and a Speech and Language Therapist (SALT) all provided by DHC. These practitioners are embedded into the pan-Dorset youth justice process and are well placed to identify and meet the needs of young people who are often difficult to engage with or have previously unmet need. Young people entering into the criminal justice system will, once allocated a YOS caseworker, partake in a comprehensive health assessment screening process which can result in referral to, for example; CAMHs, SALT or substance misuse services.

This is important work to identify the needs of vulnerable young people who may previously have unidentified needs met that could have led to them undertaking criminal behaviours.

1.26 One YOS nurse is an accredited Eye Movement Desensitization and Reprocessing (EMDR) therapy practitioner. EMDR is an integrative psychotherapy approach proven to be effective in the treatment of trauma. There are plans for the remaining two nurse practitioners to undergo the same accreditation process. This is innovative practice to meet the needs of children and young people who may have experienced trauma, including those separated children seeking asylum, at the earliest opportunity.

2. Children in need

2.1 When Bournemouth adults present at Poole Hospital NHS Foundation Trust ED, the 'Think Family' model is not routinely considered to identify children with who they may have contact. The assessment paperwork does not prompt practitioners to capture details of children of adults who attend the ED and the electronic patient record system does not allow this information to be readily stored. Records seen did not contain evidence of exploration of an adult's social or family makeup even if they had presented as the result of their risky behaviours and might have parental or carer responsibility for Bournemouth children. There is no oversight of whether clinicians are asking about potentially 'hidden children' and therefore the trust cannot be assured that risks to children and young people are being fully considered and acted upon where necessary. **Recommendation: 3.2**

2.2 Information sharing between Bournemouth maternity services and the health visiting service requires improvement. Evidence was seen during our review of historic safeguarding concerns and important information not being readily shared between midwifery and health visiting, which was not in the best interest of the women accessing the service. The Bournemouth health visiting service is now part of the 'Better Births Early Adopters' project which should see improvement in this area. However, at the time of our review it was too early to see the impact of this pilot. **Recommendation: 6.1**

2.3 In midwifery, we saw that liaison with the perinatal mental health service and substance misuse and community mental health teams is good. We saw evidence of timely referrals to these services and of good ongoing communication leading to women being supported effectively and risks to both the mother and baby are considered and managed well.

2.4 Health visitors do not always act quickly or decisively enough to identify and escalate safeguarding risks to children's social care. Evidence was seen of practitioner persistence in attempting to contact a mother where there was difficulty in engagement, in addition to contacting other health professionals involved. However, given the known risks to the child, we saw that there were delays in making statutory referrals into the MASH to safeguard a vulnerable infant in this case with there being an overreliance on others making the referral. This means that infant and mother may not benefit from safeguarding intervention at the earliest opportunity which is a risk. **Recommendation: 4.8.** *Public Health commissioners will also be notified of this finding.*

2.5 The quality of the school nursing service's child safeguarding practice seen during this review fell below expected standards. There is inconsistency across the school nursing service as to what information would trigger action from a school nurse, such as a decision to make a referral to children's social care. In tracked cases examined, we saw various examples of school health being told about children not being brought to appointments, domestic abuse incidents and attendances at EDs that were logged onto the electronic client records system but not followed up by positive actions.

We were told that each notification is triaged by a duty SCPHN, but we saw no record of any analysis underpinning the decision not to act. Important information was received by the duty nurse and 'tasked' to the school nurse linked to the child's school, yet still no further action was taken by any member of the school health team. This means that there are missed opportunities for interventions to safeguard children in Bournemouth. **Recommendation: 4.8** *as at paragraph 2.4 above. Public Health commissioners will also be notified of this finding.*

2.6 There is good evidence of CAMHS liaison with other disciplines and agencies to share information (where appropriate) of cases held. We reviewed examples where practitioners had liaised with a range of other health disciplines and agencies such as social care, housing and the YOS consistently. This leads to informed joint decision making and improved safeguarding of children and young people.

2.7 Young people accessing support regarding their mental health do not experience a smooth and planned transition into adult mental health services in Bournemouth. We heard that only one or two young people a year are transitioned into adult services following treatment with CAMHS. Recognising that this is an area for development, a CAMHS transition lead has been identified who has co-produced a transition workshop for young people with a peer specialist. This is in the early stages of roll out and has not been audited at this stage.

A transition protocol has been developed with the aim of ensuring that this process occurs in a collaborative way and encourages identification of needs at an earlier stage. Workshops for both adult mental health and CAMHS staff have been held, jointly facilitated by CAMHS and adult mental health leads with the aim of improving transitions for young people and increasing staff understanding of the protocol and encouraging collaboration between the two. However, it remains too early to measure the impact of this initiative. **Recommendation: 4.9**

2.8 Relationships and working practice between the adult mental health service and the adult Addaction substance misuse service have recently improved because of joint workshops undertaken between the services. Practitioners from both disciplines attended sessions focusing on learning from critical incidents and using complex case examples to increase understanding of each other's thresholds and service offer. This means that practitioners will have a better knowledge and understanding when working with clients who misuse substances and also live with mental health issues. It is also an opportunity to share knowledge of parental and caring responsibilities.

2.9 Despite histories or patterns of domestic abuse being a strong theme in Bournemouth domestic homicide reviews, adult mental health practitioners told us that they have not received any additional training on the subject to support clients within their service, this despite MARAC training being made available to all staff members. The service is represented at Multi-Agency Risk Assessment Conferences (MARAC) by the safeguarding children's team where multi-agencies share information regarding the highest risk domestic abuse cases. However, at the time of our review, leaders were not clear about how information held within the service is used to inform multi-agency decision making processes. Leaders within adult mental health services did not display an understanding about how outcomes and actions arising from the MARAC are relayed back to the clinician working with the individual or what impact intra-familial domestic abuse and violence has on children within those families.

This means that practitioners may not be fully equipped to support domestic abuse within their client group and thus protect vulnerable child witnesses to such abuse. **Recommendation: 4.10**

2.10 During our review of the adult mental health services, we met with a professional who was unable to readily identify children associated with adult service users in a manner supportive of the open nature of the review process. This meant that we were not able to easily obtain information that might have resulted in more positive findings in favour of the provider or have resulted in recommendations to improve safeguarding procedures to better support vulnerable children and young people in Bournemouth.

2.11 Adult mental health practitioners are not readily identifying young people who are young carers to parents who live with poor mental health. During our review leaders were not able to provide any evidence of referrals made to support this vulnerable cohort or any oversight to better identify them. This is a missed opportunity to provide intervention to hidden children who carry this responsibility that can impact negatively on their lives.

We have since been informed of plans to update the RiO electronic client records system to better identify children and young people in adult records but as this had not yet been implemented we are not in a position to report on it.

Recommendation: 4.11

2.12 There is a new clinical lead in place at Bournemouth CASH services specifically in relation to the early medical termination service. This service is commissioned by the CCG and has a single access telephone contact line for simplicity hosted by the British Pregnancy Advisory Service. Comprehensive consultations take place with young people using the service so that important safeguarding and domestic abuse questions can be asked and risks identified at an early stage.

The treatment process requires the young person to re-attend the clinic for further treatment and consultation. The service has close links to both Bournemouth and Poole hospitals maternity services and, following on from the process, further work is undertaken to ensure the young person understands the importance of ongoing contraception. This is good practice to support those vulnerable young people and ensure they receive the most appropriate care and support.

2.13 Referrals made to children's social care by practitioners at the CASH services were seen to be detailed and included information pertaining to vulnerabilities and protective factors. They were also seen to contain detail of significant adults, siblings and other family members where known. However, they could be strengthened further if practitioners included more details about what measures they would like social care to take to protect the young person, and the reasons why.

In one case examined for example, we saw how a young person was known to be extremely disruptive in school and had accusations made against them of a sexual and bullying nature. Whilst detail of this behaviour was detailed in the referral and practitioners we spoke with were able to describe local discussions regarding the rationale for the referral, nowhere was it suggested that further investigation with the young person might uncover the reasons for this which might have included them being, for example, the victim of some sort of abuse or bullying themselves.

We are aware that local discussions had taken place regarding the cause for the young person's behaviour, including the possibility of sexual abuse as a victim, but this was not brought to the attention of children's social care. *Public Health commissioners will be notified of this finding.*

2.14 The CASH targeted outreach service takes referrals into the service from anyone, including professionals, family, friends or even self-referrals. This can be done using the website online referral form which, once completed and sent, results in a return email confirming receipt and detailing the approximate waiting times for contact to be made. Consent will always be sought and obtained when information might be shared when entering into the service. Once the referral has been assessed and consent obtained, the subject of the referral will be allocated a support worker on a one-to-one basis to provide care and support as required.

2.15 Young Addaction Bournemouth will provide care and support to young people up to age 25 if they are better suited to that service as opposed to the adult service. This includes young people who access care and support who might have recognised Special Educational Needs or Disabilities (SEND), recognising their additional vulnerabilities. This is good practice in meeting the needs of young people who might not feel safe receiving support from an adult oriented service.

2.16 We spoke with the parent of a young person with SEND about the support they had received from dental services in Bournemouth. They told us that they did receive good support for their child after challenging the service proposed waiting times for treatment, but at no time was there any exploration by the dentist of any potential safeguarding issues that might have led to the young person requiring treatment. Dentists are well positioned to recognise and report oral neglect as a possible safeguarding issue and thus help vulnerable children and young people at an early stage and we are unaware of links between services to utilise information sharing opportunities.

2.17 There are effective systems in place to identify children and young people at risk. GP practices hold a 'list' of vulnerable children (including children with historical concerns) and these are discussed at monthly safeguarding meetings with the multi-disciplinary team which includes health visitors. Information is collated to ensure health practitioners can recognise increasing or decreasing risks. We heard that safeguarding meetings are a priority and are never cancelled. Therefore, children and young people at risk have their needs regularly identified and reviewed by the GP surgery to identify risk and protect them from harm at an early stage.

2.18 Practices to identify children and young people at risk of child sexual exploitation need to be strengthened in GP surgeries. GP's were aware of the CSE screening tool and have completed training on CSE. However, in one case reviewed we found that a young person who had multiple potential risks of being sexually exploited was not screened using any CSE tool. The use of assistive tools where risk is identified assists frontline practitioners in undertaking a more comprehensive risk assessment which can aid them in referring cases so that further support can be considered. **Recommendation: 1.1**

In one case examined we saw how a young person had attended the GP practice with abdominal pain and requested information regarding a possible sexually transmitted infection. This young person was noted to have had a contraceptive implant fitted at a young age at a local clinic. The young person also had a history of mental health issues and was appropriately 'flagged' on the patient electronic records system at the practice as being vulnerable. It was noted that the young person had attended with their mother, but the name of the person accompanying the child to the surgery was not recorded. No CSE screening tool was used to assist the risk assessment process during the consultation. This means that there was a potential missed opportunity to safeguard this young person from harm.

2.19 The identification of domestic abuse could be strengthened in GP surgeries across Bournemouth. GP's are not always recording when they have made a routine enquiry about domestic abuse with their patients or what the outcomes of those enquiries (if made) are, such as a referral to social services. This means that GP's cannot be assured that they have screened their patients for domestic abuse as appropriate. **Recommendation: 1.2**

2.20 GPs consider well individual diversity amongst their client groups. In one practice we visited we saw how practice staff had undertaken training on how best to provide care and support to transgender patients. The practice plans to make the lavatories and the appointment call system at the surgery gender neutral and recognised the importance of listening to children's thoughts and wishes regarding their gender so that support can be given at the earliest opportunity. This means that children and young people who visit their GP to talk about these facts will have their needs better met.

3. Child protection

3.1 In Bournemouth midwifery services, copies of referrals to children's social care and reports for case conferences for unborn babies are routinely copied to the Lead Midwife for Safeguarding. However, these are not routinely attached to the mother's record but held on a shared drive within a safeguarding folder accessed by a limited number of senior midwives and the 'Sunshine Team'. This means the patient record is not complete and practitioners accessing those records will not be able to readily access important information that might better influence their interactions with vulnerable expectant mothers. **Recommendation: 2.1**

3.2 Clinicians within Poole Hospital NHS Foundation Trust ED are not supported by efficient referral systems into other services due to the process requiring forms pertaining to Bournemouth children to be faxed to children's social care, CAMHs and substance misuse teams. These systems increase administrative time and create barriers to referrals being made into appropriate support services for children and young people who might attend Poole hospital from the Bournemouth area. **Recommendation: 3.3**

3.3 Where risks have been identified to Bournemouth children and young people attending the Poole Hospital ED, actions (such as informing multi-disciplinary partners) are not always carried out to ensure that they are supported effectively. Records seen highlighted that actions identified following safeguarding assessments were not always completed. This means that other services working with a child (such as Bournemouth school nurses) may not be aware of the ED attendance or referrals designed to support a child or family may not have happened. **Recommendation: 3.4**

3.4 All health Trusts across Dorset have fully implemented the Child Protection Information Sharing project (CP-IS) which means that RBH and Poole hospitals have the ability to check all children who visit an accident and emergency centre from outside of the area and are registered via CP-IS. Bournemouth Borough Council and the Borough of Poole Council however, have not implemented CP-IS to date, which means they are unable to check children who reside within their own local authorities.

NHS England have a robust implementation plan in place for CP-IS to be in place by March 2019. However, at the time of our review there remains risk that information pertaining to safeguarding vulnerable children and young people might be missed.

Recommendation: 1.3

3.5 The RBCH FT safeguarding team review the records of any child or young person who attends the Royal Bournemouth ED to ensure all relevant referrals to primary care or social care have been made. The team also review the records of any adult who attends the ED with a mental health condition or having misused substances to ensure the adult's contact with children has been assessed and referrals have been made where necessary. This ensures continuity of process and robust follow-up where a referral is seen to be weak.

3.6 There is a robust electronic patient records system in place in the Royal Bournemouth Hospital ED which facilitates well the safeguarding of children and young people. Young people aged 18 and under are 'flagged' on the system so that clinicians accessing the record are alerted to the young person's age. Practitioners must complete a mandatory safeguarding risk assessment as part of the discharge process. A form is automatically generated and is electronically sent to the GP, health visitor or school nurse and, if required, to children's social care. A further form is completed for children and young people who leave the ED without being seen so that appropriate action can be taken. Referrals to CAMHs can also be generated using this system.

This means clinicians must consider safeguarding as part of the routine discharge procedure and this cannot be bypassed. The process is streamlined which allows practitioners to spend more time delivering care and support to vulnerable children and young people.

3.7 There are robust and sometimes innovative systems in place to ensure children's safety in the ED at Bournemouth Royal Hospital. For example;

- The department runs training simulations which identify potential safeguarding issues and in one example seen it was identified that the paediatric emergency drug box was not easily accessible to practitioners. As a result of the simulation, the drugs box is now stored in a keypad locked fridge in the area designated for paediatric resuscitation and therefore can be promptly accessed when required.
- There are electronic systems in place to calculate drug dosages for children to reduce the risk of practitioner error.
- There is a screening tool used to risk assess how a child or young person should be transported if they are being transferred to another hospital. The tool includes consideration of safeguarding issues during transit.

These improvements lead to reduced risk and improved outcomes for children and young people.

3.8 The Bournemouth health visiting service receive timely notifications regarding safeguarding incidents pertaining to children and families open to the service. Attendances at the ED from both Bournemouth and Poole hospitals are communicated to the team in addition to Police Protection Notices and presentations at the MARAC. This means that health visitors are well informed of emerging risks to children and families and are therefore able to offer support at times when risks may have escalated.

3.9 Health visitors make good use of alerts on electronic patient records to ensure that risk and vulnerability factors are easily identifiable. Children who are subject to statutory proceedings such as child protection or child in need measures, or who are looked after, are clearly flagged on the system. This means that clinicians and managers accessing the record are quickly prompted to consider additional risk pertaining to the child of family when planning visits or interventions.

3.10 Health visitors prioritise attendance to child protection and child in need meetings and core groups. Despite times where reports have not been submitted to initial child protection conferences due to staffing shortages or late notification, there is clear evidence of a commitment to engage in statutory processes by health visiting service. Copies of minutes from both strategy meetings and conferences are held on the child's record which ensures that practitioners working with the family are aware of the risks and support plan from a multi-agency perspective and further that those records are also complete.

3.11 Infants of families who are not brought to health visiting appointments can benefit from process in place to highlight and escalate concerns when they have not been seen as expected, although we did see examples of delays in making statutory referrals. In some cases, evidence was examined of health visitor persistence in following up missed appointments and liaising with other relevant professionals when an infant is not brought. Concerns are discussed with the trust safeguarding team and contact is made with social care if the child is known to them. This means that attempts are made to locate children and ensure that they are safe and well alongside their parents.

3.12 MASH strategy meetings are regularly attended by a member of DHCs safeguarding team who supplies health information taken from the child's record and feeds back to the school nurse team via a standard letter. However, letters examined were seen to be of generally poor quality, sometimes missing significant pieces of information and the actions undertaken by school nurses were simply to attach the information to the electronic patient record and not take further action such as a risk assessment. This means that the child's record lacks information regarding what risks and protective factors were discussed during the strategy meeting and does not contain the analysis underpinning the decisions made at the meeting to inform the ongoing or planned school nurse intervention with child and family. Identified risks to the child are not clearly articulated and this leads to potential missed opportunities to safeguard children. **Recommendation: 4.12.** *Public Health commissioners will also be notified of this finding.*

3.13 Within the school nurse service, there is confusion amongst frontline practitioners regarding roles and responsibilities for safeguarding children. In one tracked case examined we saw that a child who was subject to a child protection plan attended the Bournemouth ED stating they had been assaulted. However, the child left the department after triage without being seen by a doctor. The ED notified the school nursing service on a safeguarding notification 'amber' level form. The ED did not note that the child was subject to a child protection plan (possibly hampered by the local authority currently not using the CP-IS and it is not clear what actions ED staff took when the child left the department other than notifying the school nursing service. The school nursing service simply attached the notification to the child's electronic record and took no further action, such as undertaking a risk assessment. Again, this was another missed opportunity by two health services to safeguard this child. **Recommendation: 6.2.** *Public Health commissioners will also be notified of this finding.*

3.14 Safeguarding concerns were not consistently 'flagged' on the school nursing electronic client records system. We saw, for example, that there were no 'flags' on the system to alert practitioners working with the young people that domestic abuse was a feature in their family life. This means that when domestic abuse and/or ED attendance notifications are received, it is not made easy for practitioners to identify reoccurring risks and patterns. Notifications appeared to be considered on an individual basis with no analysis of cumulative risk factors. This means that safeguarding decisions are potentially being made without a full understanding of the child's history. **Recommendation: 4.13.** *Public Health commissioners will also be notified of this finding.*

3.15 Safeguarding record keeping in some of the cases we examined in the CAMH service were incomplete. We noted for example, occasions when information relating to child protection conferences and safeguarding information was missing from the case progress notes. Health practitioners did not add their own minutes from safeguarding meetings to the system and relied on social care to provide minutes (which were not always received or 'chased up'). Also, children and young people's files were not consistently flagged with a safeguarding alert to notify practitioners accessing the records of risk at the earliest opportunity to inform the way that they deliver care and support.

We are aware that leaders know of this issue and have raised this with practitioners in business meetings. A new record keeping audit introduced in September 2018 contains the use of safeguarding status alerts on the RiO electronic patient record system to allow improvement and monitoring. However, at the time of our review the impact of these initiatives could not be evidenced. **Recommendation: 4.14**

3.16 There is currently no process for management oversight of safeguarding referrals made by practitioners in the CAMH service. In cases we reviewed, we noted that practitioners were good at following up children and young people who were noted to be at risk. However, there is no policy to check a response has been received from social care following a referral or that outcomes are received from social care. Currently, staff copy all safeguarding referrals made to Trust safeguarding team to allow the named safeguarding nurse to maintain oversight over the consistency of referrals made by Trust staff in general'

There is a current workstream to develop a Trust wide mechanism for retrieving data on referrals made to children's social care by Trust services. This will enable the safeguarding children service to report on this data and dip sample referrals for quality, feeding back findings to service leads & the 'think family safeguarding group'. At the time of our review however, managers could not be assured of the quality of safeguarding referrals or of the response as tracking did not routinely occur. **Recommendation: 4.15**

3.17 In case files we both sampled and tracked in Bournemouth CAMHs, we noted there was a generally good understanding of safeguarding risks to children and young people. However, in some of the cases we tracked across services there were repeated missed opportunities to take robust action to ensure the child was safe. Oversight of case work needs strengthening to ensure vulnerable children and young people are kept safe. **Recommendation: 4.16**

In one case we tracked across services in Bournemouth, we saw how a very young pregnant woman, who was a client of the CAMH service, had experienced several episodes of domestic abuse, mental ill health and was known to misuse substances both during pregnancy and after the birth of her child. During her antenatal engagement with CAMHs there was no evidence of risk assessments being undertaken to consider the safety of or the impact of the mother's prescribed medication upon the unborn child. In the postnatal period, successive failures to engage with the CAMH service (missed appointments) did not result in further escalation to children's social care. A later episode of domestic assault with clearly evident risk features in respect of the infant was not recognised as a safeguarding issue and no additional action was taken to bring the matter to the attention of children's social care.

3.18 There is more to do to embed the 'Think Family' model within adult mental health services. For example; children are not consistently recorded in the electronic patient record system. Clinicians are not supported to identify children as assessment documentation lacks specific questions which would encourage exploration of potential risks to children. The attitude of managers was also of concern, as it was not recognised by them that young adult males in treatment may have contact with other children or younger siblings within their family who might therefore be vulnerable. Furthermore, when an adult client commences medication prescribed by the service, there was no evidence of any assessment of potential risk to children who may also live or attend the family home. This creates a possibility that deterioration in an adult's mental health may not be fully considered in relation to the impact this could have on children they have contact with. **Recommendation:**
4.17

3.19 Bournemouth CASH services assess well the vulnerabilities of children and young people who attend the service. At first contact practitioners use a comprehensive assessment tool based on the 'spotting the signs' model. We examined completed initial and review assessments and saw that they were comprehensively filled in with the young person, clearly identifying need, vulnerabilities and supportive factors for example; from within the family or when in education. This enables practitioners to better understand how to provide appropriate care and support but also when to make referrals to children's social care.

3.20 CASH services maintain a detailed spreadsheet of young people who have identified vulnerabilities, such as when they are the subject of child protection measures, are a child in need or may be missing from home or at risk of CSE. The spreadsheet includes not only those young people who are or have previously accessed the service, but also those currently not known to the service. This means that should a previously unknown young person attend a clinic then the care co-ordinator can check the spreadsheet to ascertain if there are any additional vulnerabilities they might need to be aware of that might better inform their interactions with those young people.

The DHC safeguarding team send monthly updates to the CASH service which includes the 'top ten' children and young people at risk due to being missing from home or at risk of CSE. This is good practice and helps provide a co-ordinated approach to the early identification of risk to this vulnerable cohort of children and young people.

3.21 Whenever a young person re-attends CASH services, either as a return client or as part of an ongoing service plan, and if more than five or six weeks has passed since the last contact, then practitioners will undertake a full 'spotting the signs' assessment to identify any additional vulnerabilities since the last assessment. The process is also undertaken should the young person declare that they are, for example, in a new relationship. This provides continued safeguarding support to vulnerable young people.

3.22 Care co-ordinators at both the young person's and adult substance misuse services are active in engaging in the child protection process and will attend initial child protection meetings and, where possible, core groups and child in need meetings. Reports are submitted to inform the process when a care co-ordinator cannot attend meetings, but they are not submitted when they attend those meetings in person. We also saw that reports submitted to inform those meetings were basically a chronology of contacts with the young person concerned and did not clearly articulate personal assessment of safeguarding risk. There is risk also that, for example, should the care co-ordinator not be able to attend a meeting then because they had not prepared a report the meeting might not have important information to inform decision-making processes.

3.23 Substance misuse services in Bournemouth benefit from a lead who attends MARAC weekly meetings and also leads on the MARAC steering group. Information is shared at those meetings as appropriate and actions from those meetings is then further shared with care co-ordinators to better inform their interactions with service users.

3.24 GPs are not always considering when to make a referral to children's social care. In one practice we visited we saw that they kept an up to date list of vulnerable children and young people. Children were also added to this list if there were concerns about an adult in their home and referrals were made accordingly if considered appropriate. However, in one of the cases we tracked in Bournemouth we saw that there were missed opportunities to report risks to both an unborn child and the young mother at an early opportunity by making a referral to children's social care. **Recommendation: 1.4**

In one case we tracked at a GP practice we saw that a young expectant mother had attended the practice for a GP consultation. Although the GP was aware that the mother had been the subject of domestic abuse, was known to and receiving support from CAMHs and was further misusing substances while pregnant, the GP did not make a referral to children's social care in relation to either the mother or her unborn child. This was despite the GP recognising the need for additional support during the pregnancy. This was a missed opportunity to protect the unborn child and the young, expectant mother.

3.25 Children who are not brought for appointments are followed up diligently by GPs in Bournemouth. Every missed appointment is reviewed by a clinician for any potential risk. Children and young people will then be invited back by telephone for another appointment. If two or more successive appointments are missed, the surgery will then consider making a referral to children's social care.

One GP practice we visited runs a report each month regarding under 18's who have missed GP appointments more than once, and these children and young people's records are then reviewed to analyse their safety. This means that health practitioners safeguard those children and young people who are at risk of having their health needs un-met by not being brought to appointments.

4. Looked after children

4.1 The operating model for the looked after children service in Bournemouth is undergoing a period of transformation. There are two providers; PHFT assess the health needs of children new into care via the Initial Health Assessment process and DHC looked after children nurses then continue their care via the Review Health Assessment process. DHC provide business support for both of these services through the looked after children's health team.

4.2 There are four looked after children teams across the county of Dorset with two of these in Bournemouth and Poole. The Bournemouth & Poole team recently merged in preparation for the Local Authority merger in April 2019. Currently, the service for Bournemouth and Poole is provided by one team whilst Dorset's service is provided by a separate team. The looked after children's service has recently undergone a recruitment process to fill vacant posts and will be at full complement with the appointment of an emotional health and wellbeing practitioner in December 2018. The looked after children team provides an additional emotional health and wellbeing service for children who need support to build resilience and manage anxieties.

The emotional health and wellbeing practitioner carries out a range of lower level interventions for children with emotional needs that would otherwise not meet the criteria community CAMH intervention. We saw that this had benefitted a number of children whose records we reviewed, including one child who was still in primary school. In the case of one older, separated young person seeking asylum, the practitioner had supported them with therapeutic work to help them to understand and manage their feelings arising from a traumatic experience in their country of origin.

4.3 Where possible, Bournemouth looked after children nurses will travel up to one hour or 60 miles to maintain contact with those children placed out of the Bournemouth area. They will also endeavour to 'track' those looked after children placed out of the local area with their social workers. This practice maintains some continuity, especially where relationships have been established.

4.4 Referrals to the CAMH service are prioritised onto a four-week or an eight-week waiting list for assessment unless immediate, urgent need is identified. An appointment is offered by telephone for the more urgent four-week wait pathway and an 'opt in' letter is sent for the eight-week pathway. We were advised that, although looked after children are not automatically given priority, each case is considered individually and that they will generally only wait four weeks for an assessment recognising their additional vulnerabilities. This means that children and young people are more likely to receive the most appropriate service to meet their needs in a timely manner.

4.5 More work is required to ensure that initial health assessments of children from Bournemouth who are placed into care out of the area are carried out within statutory timescales. All seven of the assessments carried out since April 2018 on children placed out of area were seen to be over the statutory timescales. The data collected by the team that provides a narrative of why assessments are delayed shows one of the reasons for the delay recorded as 'child out of area'. A child placed out of area is not a valid reason for the assessment being delayed and there was no evidence that such delays were challenged with the receiving out of area providers. This is not an equitable service for children placed elsewhere and means there is further delay in ensuring their health needs are met. **Recommendation: 7.1**

4.6 The quality of health assessments for looked after children is assured by a process of dip-sampling 25% of the overall assessments completed in any given time. The specialist looked after children nurses and the named nurse perform this role for review health assessments carried out by the specialist team and by health visitors, whilst the designated doctor for looked after children (PHFT) undertakes this for initial assessments. Since September 2018, medical advisers have had individual supervision for a minimum of an hour a month to discuss the issues highlighted in quality assurance processes. There is also a medical adviser team meeting every other month for two hours to discuss broader issues including themes picked up in quality assurance processes.

However, there is limited evidence of the impact of the quality assurance process on improving the quality of health assessments, particularly for initial health assessments but also those review health assessments carried out by health visitors. **Recommendation: 7.2**

The looked after children service have introduced three monthly reviews of the progress of the health action plan arising from all health assessments. This is an unusual feature of the looked after children health process that improves oversight of each child's health interventions and prevents drift between statutory reviews. It involves a review of the records and consultation with the child's foster carer and social worker. In some cases, it may also involve a face-to-face meeting with the child.

Practitioners reported that this initiative could be time consuming, but that it enabled them to consider additional work to follow-up incomplete actions from the assessment, and this was evident in every record we examined. For example, for one teenage young person, their first three-monthly review in June 2018 enabled the looked after children nurse to check the significant progress of work by the emotional health and wellbeing practitioner to help the young person build resilience. Their second three-monthly review in October prompted the nurse to follow-up his dental appointment for some major dental work to be carried out.

4.7 Health visitors have improved their competence and confidence in undertaking review health assessments following training delivered by the looked after children's health team. This has increased communication and understanding between the two services and improved the quality of the health assessments completed which benefits children who are looked after. However, there is more to do to improve the quality of those assessments undertaken.

4.8 In both initial and review health assessments, the voice of the child or child's lived experience was inconsistently captured, although this was generally stronger in review health assessments than in initial health assessments examined. In some cases seen, records showed that the child had been enabled to contribute their views and feelings and this provided the assessing clinician with good information to support the assessment. In most other cases however, this contribution was limited. For example; in the records of review health assessments of three pre-school children, in the section marked 'child's views of their placement' the phrase 'child too young' was recorded. However, any opportunity to explore the child's 'lived experience' (such as the home environment or family make-up) was also not explored.

This failure to capture the child's views or record their lived experience indicates that the child was either not asked the question, not given the opportunity to express an opinion or that home and family factors were not explored by the practitioner undertaking the assessment. **Recommendation: 7.3.** *Public Health commissioners will also be notified of this finding.*

4.9 Review health assessments we examined were generally of a better quality than initial health assessments, with evidence of parental health histories being sought in most cases. This was particularly the case with those assessments carried out by the specialist looked after children nurses pertaining to children of the age of five and over. There was also much more detailed information in review assessments that provided a clearer picture of the child and their health needs. Further work is required, however, to strengthen the assessments of children aged five years and under carried out by health visitors.

Despite some training being provided by the looked after children nurses for health visitors, the records of review assessments for younger children lacked the same level of detail as those for older children. **Recommendation: 7.4.** *Public Health commissioners will also be notified of this finding.*

4.10 Except for those assessments of separated children seeking asylum, the overall level of detail in initial health assessments was sometimes limited. For example, we saw that there was limited focus and examination regarding the risks of CSE in older children, with no information about such risks being recorded in the section that specifically prompts the practitioner to consider this question. This lack of information was also notable in respect of the absence of parental histories.

We acknowledge that this information might ordinarily be available from the local authority at the point of the request for service through completion of a 'parental history' form or a 'mother and baby' form and that these are often missing from the notification documents. However, there was no evidence in the records that this missing information had been 'followed-up' before or during the assessment. Furthermore, when parental histories were absent from the initial assessments, this gap was perpetuated in a small number of review assessment with some children's records showing that parental histories were not considered at the first or subsequent review. The absence of parental histories means that specific health issues, such as, for example, inherited conditions may not be considered.

Recommendation: 7.5

4.11 The 'request for service' form used by the local authority to notify the looked after children service of a child coming into care is submitted in a timely way. However, this is a locally devised form and does not contain sufficient detailed information to enable the looked after children's service to understand the specific situation of each child coming into care. In order to gather this information, the business support staff in the service use read only access of the local authority system to populate the initial sections of the Coram/BAAF templates used by the service to document the process and the assessments.

This is a cumbersome process and means that key information about a child's family and social situation is not routinely obtained. There is a reliance on the 'parental history' and 'mother and baby' forms being submitted by the local authority, but as we outline above, these are not always submitted. This means that the assessing clinicians are not always in possession of all the information they need to make an accurate assessment of a child's health needs. **Recommendation: 7.6**

4.12 The DHC looked after children service have engaged the local Children in Care Council (CiCC) to better understand the ways in which the service is accessed by children and young people. This has been done through the production of a video by the looked after children team intended to be played to the young people at the CiCC meeting. This is a creative way of engaging young people who had suggested that this type of medium should support a meaningful consultation. This resulted in feedback about the use of the service's website and the use of text messages to communicate better with young people and these have been adopted by the trust.

4.13 In records examined within the looked after children's service, we saw that there is variable evidence of faith or culture being considered as part of the health assessments. In the case of an older separated child seeking asylum, the young person's faith was a key factor in assessing the health needs (they had sustained an injury when fleeing Sudan and this affected their ability to attend to the mosque). However, this was an isolated example, and this section of the assessment documentation was mostly left blank in other records we reviewed.

Recommendation: 7.7

4.14 DHC have, in close conjunction with care leavers, produced a leaving care passport known as 'Me and My Health'. This passport style booklet is provided to young people as they leave care and is completed with information by the looked after children nurse in collaboration with the young person. This ensures that only the information required by the care leaver is included within the book.

4.15 Dedicated psychologists provide support to professionals and carers working with children and young people who are adopted or who are looked after by foster carers or family members within the CAMH service. The team aims to increase understanding of children's psychological needs and promote resilience amongst carers to reduce placement breakdowns and improve the mental health of looked after children. However, at the time of our review the impact of this service had not yet been measured.

4.16 Practitioners within the CASH service have developed strong links to the looked after children team and local youth workers. Those relationships mean that vulnerable children and young people can be supported by multi-agency practitioners as they want, including those youth workers attending CASH appointments with the young person.

4.17 The local area has a robust system in place to ensure GP's are aware if they have any separated children seeking asylum registered with their practice. A named GP identified that surgeries were not being given full information on the young person's status other than that the child was looked after. The named GP advises on where to place the children within the local area so that they have easy access to the hospital which delivers the type of healthcare they need. They also ensure the receiving GP practice is fully aware of the child's status and relevant background information is highlighted. This means that young people accessing their local GP surgery benefit from treatment from a clinician who has a full understanding of their history and needs.

4.18 The YOS have recently developed links to the looked after children team with both services recognising that looked after children have an increased risk of entering into the criminal justice system. The YOS team recently attended a looked after team 'away day' event so that relationships could be built on with the aim of reducing duplication of interaction with vulnerable looked after young people.

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 Multi-disciplinary practitioners across health can partake in a half-day shadowing of processes within the MASH to gain a better understanding of how the MASH works. This is a good opportunity to improve safeguarding knowledge for those practitioners and promotes better quality and timely referrals to help protect vulnerable children and young people. However, all the practitioners we met with this week have been unaware of the offer even though we were told the offer has been in place for approximately a year. **Recommendation: 8.1**

5.1.2 Health practitioners within the MASH are considered equal partners by their multi-agency colleagues within the unit. There is a good understanding of each other's roles and responsibilities and good management of information sharing by health to ensure that requests made are proportionate and justified to help protect children, young people and their families.

5.1.3 There is currently no quality assurance by health managers of referrals made by health practitioners considered at the 'front door' by social care practitioners that do not meet the threshold for MASH consideration. We are not aware how health managers can be assured that those social workers are appropriately considering health information when making their decisions. There is risk therefore, that some cases might be 'missed' as appropriate for ongoing referral to the MASH due to those social workers not understanding potentially important health information that could be subject to further test. **Recommendation: 4.3**

5.1.4 The RBCH FT Head of Midwifery has not been able to fully cover all aspects of the Named Midwife role. It is not clear what Trust oversight there has been regarding this. However, this is currently under review as a result of the proposed merger in 2020 between Bournemouth and Poole Trusts.

5.1.5 We were told this has been somewhat mitigated by the involvement of the Named Nurse for Safeguarding Children in offering some support and advice to the midwifery teams, but there remain gaps in, for example, the provision of safeguarding supervision to community midwives and those working within maternity units in Bournemouth. **Recommendation: 5.3**

5.1.6 Leaders within the health visiting service recognise that practitioners are struggling, at times, to meet the needs of the population, despite staffing issues no longer presenting as a problem. For example, disproportionate caseloads held by practitioners in health visitor teams where it is recognised that there are higher levels of deprivation. The clinical manager for the service is working alongside the business and performance team to complete an accurate productivity assessment. This will enable the service to establish a clearer picture of the service's needs and resources required with the aim to provide a more equitable health visitor workload across Bournemouth. *Public Health commissioners will be notified of this finding.*

5.1.7 Practitioners within the adult mental health mental health team do not benefit from the use of 'flags' or 'alerts' used on the RiO electronic patient records system to readily identify looked after children, children in need and other children at risk of harm. We checked the patient electronic recording system and found there were no alerts to indicate to practitioners that children were at the risk of harm. This means that mental health practitioners are not well placed to identify children and young people who may be at risk or where there are recognised safeguarding concerns. **Recommendation: 4.18**

5.1.8 Some young people are waiting too long to access care pathways in the CASH service and some young people are having to wait several weeks for contraceptive devices to be fitted. However, in their attempts to recruit at the current band six level, the service manager noted that a number of qualified nurses at band five were interested in joining the service. This has resulted in a dedicated recruitment drive at the band five level where successful candidates will undertake a developmental pathway to include a faculty diploma in sexual and reproductive health. This and a dedicated mentorship programme will mean that practitioners will, once they have the required skills and experience, quickly progress to a band six level and be in a position to support those young people requiring specific contraception.

5.1.9 Leaders within Bournemouth CASH services meet on a monthly basis to discuss those children and young people identified as at risk, including the 'top ten' as further identified by the DHC safeguarding team. This process is overseen in the sexual health management meeting and referral figures shared with CCG.

5.1.10 The 'HALO' electronic client records system in use by Addaction adult and young people's services is disjointed. There is currently a mix of electronic and paper records in use and we saw examples of electronic records that were not complete as paper records of, for example, child protection meeting minutes were stored elsewhere and not scanned onto the electronic record. Likewise, we requested to see an example of a report written to inform a child protection meeting but it could not be found on the electronic records system. Incomplete records are often mentioned in serious case reviews as poor practice.

5.1.11 We heard from leaders that there are variations in the processes of how referrals are made into the MASH according to each of the three borough's, Bournemouth, Dorset and Poole. There are plans to standardise this process using single policies across the three boroughs'. This will, when implemented, strengthen further and standardise the referral process.

5.2 Governance

5.2.1 RBCH FT safeguarding leads are proactive in driving improvement in safeguarding practice within the ED at Bournemouth Hospital. Monthly dip sampling of safeguarding assessments undertaken by the named nurse for safeguarding ensures that all appropriate actions have been carried out and examples were provided of cases where additional scrutiny had resulted in further follow up actions to be completed. Where it is deemed necessary, training or support is offered to clinicians so that staff are supported to improve their safeguarding practice using real cases to aid their learning.

5.2.2 Following an audit of MASH referrals last year in conjunction with the MASH manager, work was undertaken within the Bournemouth ED to improve the quality of information between the two services. A subsequent re-audit has been carried out which has demonstrated an increase in the quality of the information submitted to inform the multiagency decision-making process at the MASH.

5.2.3 Information sharing between RBCH FT and PHT is not supported by a shared electronic patient record system. When a child is transferred from Bournemouth to Poole hospital, all information has to be printed and paper copies physically handed over. When entering Poole hospital, the assessment process must be completed again and all previously held information manually entered into the electronic patient record system which increases the opportunity for recording error. This means that, for example, safeguarding information might be missed.

Recommendation: 5.4

5.2.4 Health practitioners within the MASH are supported by administration assistants which means that those practitioners are able to spend more time researching cases referred to them. Those same health professionals work on a rotational basis between the MASH and their usual health roles. This means that those practitioners remain well placed to maintain their unique role and presence within the MASH and better utilise their health skills accordingly.

5.2.5 RBCH FT recognise the risks to children associated with adults who misuse alcohol. Training has been carried out within a key ward at the Royal Bournemouth Hospital to undertake the 'Audit C' national alcohol screening tool and an alcohol withdrawal pathway has recently been implemented. Furthermore, child admissions due to alcohol misuse have now been added to the dataset submitted to the LSCB to capture this information and increase identification of the impact.

5.2.6 Incident reporting is well used within maternity services, and there are good process in place to oversee the investigation and the learning from incidents and near-misses. Monthly risk meetings are held where all incidents and near misses are discussed and the outcomes reported into monthly open maternity risk meetings, governance meetings and to the RBCH FT risk committee. This means that learning can then be shared amongst midwifery teams so that they can put this into practice to better protect vulnerable mothers and children, including unborn children.

5.2.7 Leaders are currently in year-two of a three-year vision that focuses, in successive years, on performance, quality and sustainability within the Bournemouth looked after children service. This has seen a significant improvement, with review health assessments (including out of area placements) at over 90% coverage and three-monthly reviews at 95% coverage. This is despite a number of external looked after children nursing team's refusal to deliver review health assessments for Dorset, Bournemouth and Poole children, meaning the local team are traveling out of area much more than previously seen.

Significant developments have included the use of a performance scorecard to report to the trust's leadership internally, and to commissioners and corporate parenting boards externally. The scorecard gives leaders good oversight of the data about looked after children. It also presents a clear picture of the effectiveness of the providers in assessing the needs of looked after children and enabling them to receive health care that meets those needs.

5.2.8 Record keeping within the Bournemouth health visiting service is fragmented, and in cases examined evidence was seen regarding a lack of clarity about the outcomes of visits or plans for ongoing support. In two tracked cases examined, it was unclear to us about the level of contact with the family and also why the health visitor had stopped visiting the family. Poor record keeping restricts the ability of leaders and supervisors to gain a clear picture of an infant's care and have a full understanding of interventions which are being carried out to ensure better outcomes are being achieved. **Recommendation: 4.19.** *Public Health commissioners will also be notified of this finding.*

In one case we tracked we saw how poor record keeping made it difficult to understand where the mother and baby were residing and we could not confirm that this might have been in a risky environment.

Following a Child in Need meeting, there was a plan in place for the health visitor to continue to see the mother and baby, but access could not be gained on two subsequent visits. These were not flagged as significant events within the electronic patient record system. The child was also brought to an ED on three occasions during this period of time. There was evidence of a discussion with a social worker who confirmed that the case would be closed, but it was not clear whether these missed appointments and ED attendances were shared with the social worker.

At that point the last entry by the health visitor stated that the mother and child would be seen again in a month. However, this did not happen and no further contact was made until a strategy discussion took place two months later when concerns were raised that the child may have been subject to an indecent assault.

The mother later made a disclosure to CAMHs that she had been in a controlling and abusive relationship during this period of time, when the health visiting service did not appear to have made attempts to engage with the mother.

5.2.9 There is an absence of effective quality assurance processes within the health visiting service. This means that there is poor oversight of some areas of practice and restricts the ability to drive service improvements. **Recommendation: 4.19** as at paragraph 5.2.8 above and 5.2.10 below. *Public Health commissioners will also be notified of this finding.*

5.2.10 In the school nurse service, we examined reports submitted to inform the child protection process and found they were generally of poor quality and would not accurately inform decision-making. For example; one report seen was written about a child that practitioners had never met. In addition to this there was no practitioner analysis of risk to the child or the family. We were told that all reports seen had been quality assured by the safeguarding team (although we have since been assured that the safeguarding team 'dip sample' some child protection reports) which leaves us to question the robustness of that process. As a result, there is potential for identified risks to not be clearly articulated within the safeguarding process. **Recommendation: 4.19** as at paragraphs 5.2.8 and 5.2.9 above. *Public Health commissioners will also be notified of this finding.*

5.2.11 Managers spoke about the positive response in relation to improving the quality of looked after children health plans which are reviewed every 12 weeks either as a desk based exercise, following a phone call to the young person or carers or, where need is identified, this could involve a face-to-face meeting with the young person. The outcomes of this initiative are positive, and compliance with the 12-week review process currently stands at 100%. This process is innovative in maintaining oversight of looked after children and their health and safety needs and we examined positive results of the process in records examined and in discussion with practitioners.

5.2.12 There are good governance arrangements in place for the looked after children service with the named nurse having overall responsibility for the performance of DHC, the business processes that service both trusts. The designated nurse for looked after children is employed separately by the CCG; this ensures that any conflict of interest is minimised and enables independent scrutiny of the providers' performance.

5.2.13 There is a effective business support system in place in DHC that co-ordinates the IHAs carried out by PHFT and the RHAs carried out the DHC. This system operates well despite both parts of the process being carried out by two different providers. A tracking tool is used to manage the allocation of health assessments and the timescales in which they are completed. This enables DHC to produce good data for the scorecard.

5.2.14 Oversight of safeguarding practice in adult mental health services is weak, and during our review leaders were unable to identify the number of children attached to adults accessing their service. Furthermore, leaders could not provide examples where referrals had been made to children's social care and were not able to demonstrate knowledge of clients with children with additional vulnerabilities, such as those requiring statutory services or who are looked after. The absence of robust quality assurance and audit processes means that there is a risk that poor performance will not be detected and addressed to ensure children are safeguarded effectively. **Recommendation: 4.20**

5.2.15 There has been ineffective governance and lack of oversight on the progress of the actions from a serious case review which highlighted risks in adult mental health services. Leaders within the team drafted a synopsis of learning in August 2017 because of the serious case review. This was to highlight the learning from the review across professional networks where risks to children had been identified.

A series of actions were due to be implemented by October 2017. However, at the time of our review the progress on these actions is yet to be updated. As the action plan was not made available to the inspection team in good time, we were unable to thoroughly test how well these actions had been implemented across the service. We have since been provided with information pertaining to this particular case. However, it remains true that this information was not made readily available at the time of our review and we cannot be assured that actions have been implemented accordingly other than a care plan implemented for the adult concerned.

Recommendation: 4.21

5.2.16 In Bournemouth CASH, a recent review of the way that services are provided and in consultation with Bournemouth young people via service feedback, resulted in a change in service hours at 'The Junction' in Bournemouth. Young people can book appointments which are flexible according to their needs, including outside of school time. Where additional vulnerabilities are known, such as when the young person is a looked after child then there is even more flexibility afforded to them recognising those additional vulnerabilities. Looked after children are also, for example, offered an extra 10 minutes appointment time to allow for additional exploration of vulnerabilities. This includes meeting them at short notice and even outside of normal working hours. This is good practice to meet the needs of those young people at the earliest stage.

5.2.17 Bournemouth CASH services engage well with young people in the area by way of information technology and social media. The 'Sexual Health Dorset' website is updated on a regular basis and involves services provided at both acute hospitals. The service also maintains a presence via other social media services and by way of a monitored text messaging service. This is good practice to meet the needs of young people who routinely use these methods to communicate and share information.

5.2.18 Audit of the sexual health and relationship packages in use at schools across Bournemouth as provided by the Targeted Outreach Team has resulted in the further development of the content to better meet the needs of the young people accessing it. Where feedback was found to be neutral pertaining to areas of the package then improvements have been made to meet the needs of those accessing it. This will be an ongoing process of improvement in an innovative practice of education regarding sexual health.

5.2.19 Addaction adult substance misuse services are better able to engage with clients who might have parental or carer responsibilities due to a budget which allows them to provide financial support to those service users who might not be able to afford child care so that they can attend the service to obtain care and support. The Parental Support budget is flexible and can also be used for example, to provide kennel care for pets when an adult needs to attend in-patient care. This is innovative practice to meet the needs of adults who might also have parental responsibilities.

5.2.20 There are guidelines in place in the local area's GP practices to safeguard children and young people. We saw evidence of policies and procedures to safeguard children and young people including policies on domestic abuse, safeguarding children and adults and managing allegations against staff. GP's were aware of escalation and challenge policies and gave some verbal examples of this. Although the way that GPs record such information appears variable, overall this means that primary care health practitioners have the tools and information to identify children and young people at risk at the earliest opportunity.

5.2.21 There are currently no mechanisms in place to quality assure GP reports submitted to inform safeguarding conferences and other child protection meetings. GP's told us there was no peer review or other quality control process in place. One report we examined lacked analysis to explain why the presenting health issues were linked to neglect. This could lead to important health information not being correctly interpreted when the risks and protective factors to the child are analysed. Good quality assurance and governance of reporting procedures would improve the overall quality of reports submitted to inform decision making processes.

Recommendation: 1.5

5.2.22 There are good systems in place to audit safeguarding practice across GP surgeries in Bournemouth although this system does not currently include the quality assurance of reports submitted to inform safeguarding processes. 70 out of 89 GP practices have currently been audited. No surgery in the local area has declined the audit. The named GP's are assured every surgery audited so far has a designated lead for safeguarding children, a process for ensuring all staff are up to date with their training, a flag system to identify vulnerable patients, a register of children at risk and a named lead for domestic abuse. Surgeries will be supported to achieve these goals as required.

5.3 Training and supervision

5.3.1 Health practitioners within the MASH are trained to level four safeguarding children. This level of training means that they are better prepared to identify and meet the needs of vulnerable children, young people and families at this most important stage of the referral process.

5.3.2 Historically there have been issues with hospital staff accessing LCSB level three safeguarding children training. To mitigate this, Royal Bournemouth Hospital in association with Poole has invested in a bespoke level three training package. Leaders are aware the training is not multiagency but it is however, multidisciplinary. There has been a recent increase in the number of staff who have completed level three safeguarding training. Currently 93% of nursing staff and 83% of medical staff are compliant with safeguarding training requirements.

5.3.3 Safeguarding supervision in midwifery services requires strengthening. For example, group safeguarding supervision for the Sunshine Team is facilitated by the Named Nurse for children's safeguarding on a monthly basis and is good. However, no routine supervision is offered to the wider midwifery workforce due to a lack of adequately trained safeguarding supervisors. These practitioners can access advice and guidance, but this is not structured safeguarding supervision of their caseload.

This means we cannot be assured the confidence and competencies of the wider midwifery workforce are considered even though they carry some moderately complex caseloads and might be the only professional involved with families who are not known to social services. **Recommendation: 5.3** as at paragraph 5.1.5 above.

5.3.4 Where supervision does take place in maternity services, notes regarding that supervision or that advice and guidance has been provided, are not recorded in patient notes or in chronologies which would help identify cases where risks are emerging and make those records complete. We are further aware that there is no formal auditing of processes in relation to safeguarding practice so that leaders can be assured of its effectiveness.

Safeguarding supervision is an essential part of safe reflective practice and needs to be undertaken on a regular basis to ensure the safety of vulnerable mothers and children. **Recommendation: 5.5**

5.3.5 The skills and knowledge regarding vulnerability and safeguarding within the 'Sunshine Team' of midwives is good. All have undergone level three safeguarding children training and adult safeguarding training to level two. Practitioners have acquired additional skills in working with women who might present with mental health issues, substance misuse, be the victim of domestic abuse, live with learning difficulties, or be subjected to exploitation, trafficking, and FGM. This is good practice within the 'Sunshine Team' in meeting the needs of vulnerable expectant mothers and their unborn children.

5.3.6 Within the school nurse service, although we were informed the compliance for level three safeguarding children currently stands at 100%, we cannot be assured of the effectiveness of this training despite it's being accessed from the LSCB. For example, we found in both cases tracked and sampled within the service a catalogue of missed opportunities, failures to challenge social care decisions and poor contribution to inform safeguarding procedures. We found that those missed opportunities, particularly in cases tracked across the services, could have prevented harm at an earlier stage if they had been identified appropriately. **Recommendation: 4.22.** *Public Health commissioners will also be notified of this finding.*

5.3.7 The DHC safeguarding team made a strategic decision to develop and deliver a safeguarding supervision training course, with the aim of increasing the number of health practitioners in other teams who could provide much needed safeguarding supervision. The programme of training non-safeguarding team staff (safeguarding advisors) to provide safeguarding supervision was delivered in December 2017. However, although we were informed during our review that the school nursing team were 100% compliant with quarterly safeguarding group supervision and that the service has a safeguarding supervision policy with documents designed to help practitioners reflect on cases, we saw no evidence of the effectiveness of this in the children's records we examined.

In records examined we saw that there were continued missed opportunities to identify risk at an earlier stage which might have been identified at supervision. This leads us to question whether this supervision offer is effective. **Recommendation: 4.23.** *Public Health commissioners will also be notified of this finding.*

5.3.8 There are strong multi-layered supervision arrangements in the CAMH service. This includes quarterly group safeguarding supervision, monthly case management group supervision where safeguarding is always an agenda item, monthly clinical supervision where there is an opportunity to discuss cases of concern, daily team liaison meetings where cases are reflected upon and advice and guidance from the trust safeguarding team as and when required. This provides practitioners with plentiful opportunities to reflect on cases of concern and supports safeguarding decision making.

5.3.9 Although safeguarding supervision is documented in client case records within Bournemouth CAMHS, in records examined we saw that the standard of recording was variable. In some examples reviewed, advice and guidance that had been provided by specialist practitioners was evident, and we saw clear plans outlining the next course of action. In other records examined the level of detail was superficial, there was no analysis of risk and the recorded plan did not contain sufficient direction to staff. This could potentially lead to staff being poorly directed and to inconsistent decision making. Furthermore, there was no management follow up of actions arising from supervision sessions so the effectiveness of the supervision could not be understood. **Recommendation: 4.24**

5.3.10 Mandatory training is monitored in Bournemouth CAMHS. A training spreadsheet is held and regularly reviewed, staff are sent their training records and emailed with prompts regarding training. Leaders informed us that 97% of staff were compliant with mandatory training requirements with 84% level three safeguarding compliance at the time of our inspection. However, due to different training options available for level three safeguarding training, leaders were unable to give assurance that all staff had received an update regarding all areas of safeguarding required. **Recommendation: 4.25**

5.3.11 Practitioners within the adult mental health team benefit from regular multi-disciplinary team meetings to discuss clients. Each week the team discuss people entering or exiting treatment in addition to clients who may have escalating risks or other presenting concerns, including issues relating to child safeguarding. However, these were seen not always to be followed up or recorded well. This means that there is opportunity for reflective practice and actions generated from a multi-disciplinary perspective.

5.3.12 GP's in the Bournemouth area are in receipt of a strong supervision offer. Named GP's receive supervision from the CCG and are also members of the primary care safeguarding forum, which means they can link with other named GP's and attend the annual primary care safeguarding forum conference to keep up to date with best practice. GP's can also attend bi-monthly peer supervision sessions. All GP's receive a bi monthly safeguarding bulletin to keep them up to date with current issues. Staff within the GP surgery can speak the to the GP lead in safeguarding for advice and support as required. In turn the GP leads can speak to the named GP for advice and support as and when required. This means that all GP practice staff can seek advice and reflect on cases where there is a safeguarding concern.

5.3.13 The clinical psychologist at the YOS provides clinical supervision to nurse and SALT practitioners within the service. Safeguarding training and supervision is provided by the DHC safeguarding team, but those practitioners also take part in reflective practice groups at the YOS facilitated by the clinical psychologist. This is good practice in keeping abreast of sometimes complex issues experienced by young people who often lead chaotic lifestyles.

Recommendations

1. NHS Dorset CCG should:

- 1.1 Ensure GPs are better aware of the importance of using tools to support identified risk, including those available to better identify CSE for example, and that their use is monitored by quality assurance and oversight.
- 1.2 Ensure GPs are recording domestic abuse enquiries and the outcomes of those enquiries and then referring those results, where appropriate, to multi-disciplinary and multi-agency partners.
- 1.3 Commissioners to progress work currently underway with multi-agency and multi-disciplinary partners to assure themselves that CP-IS is used effectively across multi-agency partnerships at the earliest opportunity.
- 1.4 Ensure GPs across Bournemouth are aware of the importance of notifying children's social care when risks are identified to all children, including those unborn.
- 1.5 Put into place systems to quality assure and sample GP records produced to inform safeguarding processes when submitting safeguarding reports to ensure they are appropriate and accurately identify risk and readily inform decision making processes.

2. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust should:

- 2.1 Ensure all midwifery practitioners have routine access to both copies of referrals made to inform children's social care of risk but also that the outcomes of those safeguarding meetings are also available for reference.

3. Poole Hospital NHS Foundation Trust Should:

- 3.1 Implement methods to allow children aged between 16 and 18 years of age to choose if they would prefer to receive care and support in the paediatric or adult ED areas and further ensure methods are in place to segregate children from adults where possible allowing for the physical fabric of the current building.
- 3.2 Implement more robust processes to aid practitioners at the Poole ED to better identify children and young people in the care of adult attenders who undertake risky behaviours and record their details accordingly.

- 3.3 Improve systems of referral at Poole Hospital ED that reduce administrative time spent undertaking the process so that practitioners are encouraged to make referrals when necessary.
- 3.4 Ensure there is better oversight of identified actions following children and young people's attendance at the Poole ED and that those actions are followed up and completed.

4. Dorset Healthcare University NHS Foundation Trust should:

- 4.1 In association with social care partners, explore and implement ways to ensure original and complete copies of referrals made by health practitioners in Bournemouth should be made available to the health practitioners at the MASH to aid their research and decision-making processes.
- 4.2 In association with social care partners, explore and implement measures to better inform those making a referral to children's social care of the outcome of the referral, even where no further action is considered appropriate.
- 4.3 Implement measures to better quality assure the decision-making processes at the 'front door' in relation to referrals made by health practitioners, to be assured that decisions made are appropriate and take fully into account health information provided.
- 4.4 In association with health partners, explore methods and implement systems to allow practitioners within the MASH to task other users of the SystemOne patient record over and above 'read only' access to assist in the process of maintaining complete patient records.
- 4.5 Ensure health visitors are prompted to make enquiries regarding domestic abuse during their contacts with mothers as their children develop and that they record those interactions accordingly.
- 4.6 Implement better ways for public health nurses to act on information received (such as from the EDs or child protection processes) and act more pro-actively with children in their care and undertake health assessments and associated risk assessments where these might be considered beneficial.
- 4.7 Ensure information is better shared across all adult mental health practitioners, including those working in the community, so as to assist in implementing the 'think family' model of care for those clients not on an enhanced CPA.
- 4.8 Ensure public health nurses are aware of the importance of taking prompt action where risk is identified and also make swift referrals to children's social care where risk is identified and that leaders are assured of the quality of the process by maintaining good quality assurance and oversight of processes.

- 4.9 Monitor the role of transitions leads and bi-monthly transitions meetings to evaluate their effectiveness and review the process accordingly to ensure smooth, timely and planned transition between adolescent and adult services.
- 4.10 Ensure systems and processes are in place to enable practitioners within adult mental health services identify children in the care of adult service users, particularly where domestic abuse is indicated, appropriately share information and refer to children's social care when necessary.
- 4.11 Ensure those systems used to identify children living in households where domestic abuse is indicated also identify and recognise the needs of young people who may be carers to adult service users and information pertaining to them is shared accordingly.
- 4.12 Ensure information forwarded to the school nurse team regarding safeguarding issues and risk is accurate and recorded and used by school nurses to inform decisions made to provide appropriate care and support to children and young people.
- 4.13 Ensure electronic records are used effectively to notify public health nurses at the earliest opportunity when accessing those records of risks such as domestic abuse, CSE and where child protection measures are in place.
- 4.14 Ensure CAMH patient records are complete by including minutes of child protection and core group meetings and recommendations within those records and follow up with children's social care where minutes are not received from them. Where risks are identified then these should be highlighted on records by way of alerts. These processes should be monitored by leaders to ensure they are effective and complete.
- 4.15 Continue work already underway to ensure those identified gaps regarding referral processes within CAMHs are effectively managed and monitored by way of quality assurance and oversight.
- 4.16 Ensure systems and processes are in place across the CAMH service to monitor the effectiveness of practitioner work in recognising risk and that they are acting in an effective way to protect vulnerable children and young people.
- 4.17 Implement procedures to ensure better identification and assessment of vulnerable children and young people in the care of adult service users so that protective measures can be put in place considering risk to the family as a whole.
- 4.18 Better use electronic patient record systems to alert users of the system to the vulnerabilities of children in the care of adult service users.

- 4.19 Engage more robust quality assurance and oversight of record keeping within public health services to ensure records are both complete and reflect well practitioner interventions with families and helps to drive forward service improvement.
- 4.20 Strengthen quality assurance and audit processes within adult mental health to ensure leaders are aware of vulnerable children and young people in the care of adult service users and further that practitioners are appropriately identifying those young people and protecting them accordingly.
- 4.21 Managers should ensure that where actions are identified following serious case reviews and other serious incidents, then those action plans are readily available, up-to-date and regularly reviewed as to their appropriateness.
- 4.22 Review the quality and provision of level three safeguarding children training to assure themselves that it is fit for purpose.
- 4.23 Review the provision and quality of safeguarding supervision within the school nursing service to assure themselves of its effectiveness in aiding the protection of vulnerable children and young people.
- 4.24 Ensure that where safeguarding supervision does take place in CAMH services then those discussions, timescales, responsibilities and suggested outcomes are recorded in case records.
- 4.25 Ensure figures are routinely obtained regarding aggregated safeguarding training levels in the CAMH service so that leaders can be assured that appropriate percentages of practitioners are trained at each level of required safeguarding children training.

5. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust Should:

- 5.1 Ensure tools to aid the identification of risks, such as when CSE is indicated, are used by practitioners where risk is suspected to then aid the referral process.
- 5.2 Ensure measures are put in place to enable practitioners across the midwifery service to ask and record the answers to questions about domestic abuse at several points throughout a woman's pregnancy.
- 5.3 Ensure there is an equitable safeguarding supervision offer to all midwives who offer care and support to Bournemouth women and their unborn children at the earliest opportunity.
- 5.4 Consider and implement more robust oversight of information sharing processes to reduce the margin for error.

5.5 Ensure that where safeguarding supervision does take place in maternity services then those discussions, timescales, responsibilities and suggested outcomes are recorded in case records.

6. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust should:

6.1 Monitor the 'Better Births Early Adopters' project to assess its effectiveness and review the methodology should it be found to be ineffective.

6.2 Ensure information passed by the Bournemouth Hospital ED to the school nurse team is accurate and that school nurses better consider information received, and further ensure that decisions made are recorded and that considered actions are completed.

7. NHS Dorset CCG, Dorset Healthcare University NHS Foundation Trust and Poole Hospital NHS Foundation Trust should:

7.1 Ensure more robust action is taken to ensure initial health assessments for those children and young people placed out of area are undertaken in a timelier manner and that where this is not done then the reasons are explored in more detail and findings acted onto reduce repetition.

7.2 Review and implement improved processes of quality assurance to ensure that both initial and review health assessments undertaken across all ages are of consistently good quality.

7.3 Ensure that all practitioners undertaking both initial and review health assessments are aware of the importance of examining, understanding and recording both the child's voice and lived experience so that those assessments more accurately reflect the wishes and needs of the children to whom they pertain. This process must be assured by robust quality assurance processes.

7.4 Review training provided to health visitors in undertaking review health assessments for looked after children aged five years and under and review systems in place for assuring the quality of those assessments undertaken.

7.5 Ensure that all avenues are explored to obtain and record as much parental history information as possible to inform both the initial and review health assessment process and that this information is recorded in service user records.

7.6 Explore with multi-agency partners ways to implement and improve information gathering process to ensure both initial and review health assessments undertaken are complete with as much detailed information as is required.

7.7 Ensure faith and culture preferences are captured and recorded in both initial and review health assessments to reflect the child or young person's important preferences.

8. NHS Dorset CCG and Dorset Healthcare University NHS Foundation Trust should:

8.1 Ensure multi-disciplinary practitioners who might be in a position to make referrals to children's social care are aware of opportunities to visit the MASH so as to improve their understanding of processes there.

Next steps

An action plan addressing the recommendations above is required from NHS Dorset 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.