

Review of Health Services for Looked After Children and Safeguarding in Wiltshire

Looked After Children and Safeguarding

The role of health services in Wiltshire

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Provider services included:	Great Western Hospitals NHS Foundation Trust (GWHFT) Oxford Health NHS Foundation Trust (OHFT) Salisbury NHS Foundation Trust (SFT) Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Sirona, Bath & North East Somerset Turning Point, adult substance misuse Motiv8, children and young people substance misuse
CCGs included:	Wiltshire Clinical Commissioning Group (CCG)
NHS England area:	South West
CQC region:	South (West)
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Summary of the review

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

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review all aspects of 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. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

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

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

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

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

Context of the review

The county of Wiltshire is situated in the south west of England. It is a large, predominantly rural and generally prosperous county. Although Wiltshire ranks amongst the least deprived areas of England, it masks significant pockets of deprivation. The total population in Wiltshire is estimated to be 474,300 (ONS mid-year estimate 2011) and rising. Of this population the number of children and young people aged 0-19 is 114,801 (24.2%) which is more than the national average of 23.9%.

In 2012 Children and young people from minority ethnic groups account for 9.0% of pupils in primary schools and 7.4% of pupils in secondary schools which is significantly below the national average of 27.6% and 23.2% respectively. The largest group is made up of children and young people from black minority ethnic (BME) communities with a more recent increase of children and young people from Western and Eastern European countries. In 2012 the percentage of Wiltshire pupils who spoke English as an additional language was 3.5%

Apart from its rurality, Wiltshire is characterised by the scale of its military presence which is one of the largest in the country. This presents challenges to statutory services as well as military welfare services. Specific issues include potential turbulence in family life when parents are posted to another location and disruption to learning as children change schools. In addition, some children and young people may have difficulties with anxiety when parents are on active service overseas, which is a challenge for emotional health and wellbeing services.

Joint commissioning arrangements are in place for children's health care in Wiltshire. Wiltshire Clinical Commissioning Group (CCG) commissions a significant proportion of children's health care in Wiltshire however following the implementation of the Health And Social Care Act Health Visiting Services are commissioned by NHS England and School Nursing services are commissioned by the Local Authority. The Designated Nurse for looked-after children is appointed by public health and the Designated Doctor for LAC is also commissioned by public health. The specialist looked-after children's nurses are part of Great Western Hospitals Foundation Trust (GWHFT) and is commissioned within the Children's Community Services Contract by the CCG

In 2011/12, a higher percentage of children (94.9%) have received their first MMR immunisation dose by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower, with 88.5% of children being immunised. This is still higher than the England average. In the South West, there were 80 laboratory confirmed cases of measles in young people aged 19 and under in 2012.

In 2010, approximately 26 girls aged under 18 years conceived for every 1,000 of the female population aged 15-17 years in Wiltshire. This is lower than the regional average. The area has a lower teenage conception rate compared to the England average.

Wiltshire has a higher than national average rate of self-harm admissions but this has decreased in 2011/12 compared to 2010/11. Young people's admissions for mental health are a third lower than the national average. (CHIMAT 2013, data from 2011/12)

In Wiltshire, young people in drug and alcohol treatment are now more likely to have multiple risk indicators according to the most recent public health needs assessment refresh. There have been increases in those with three or four risk indicators, and the range of complexity amongst young people in treatment has become more complex; in 2010-11 78% had one or two risk indicators, by 2011-12 80% had between one and four risk indicators.

Wiltshire residents access acute hospital services provided by three acute trusts, Royal United Hospital Bath, Great Western Hospital Foundation Trust and Salisbury Foundation Trust (SFT). However SFT is the only acute health provider located within Wiltshire's boundaries at Salisbury District Hospital and therefore, the only acute service included in this review. Salisbury District Hospital has a 16 bedded child inpatient ward and as part of maternity services there is a neonatal intensive care unit and postnatal ward. There is a CAMHS team based on the Salisbury District Hospital site, provided by Oxford Health NHS Foundation Trust (OHFT).

Community based services including school nursing and health visiting are provided by GWHFT. Pregnant women in the north of the county have a choice of Royal United Hospital at Bath with its own obstetric unit or midwife led maternity units. All community midwifery, other than in South Wiltshire, is provided by GWHFT. The above services and the GWHFT service birthing centres in North Wiltshire were not part of this review. Women in the South have hospital or home choices. Salisbury District Hospital maternity unit and community based services extend up to the plain on north, down to Dorset and Hampshire.

Child and Adolescent Mental Health Services (CAMHS) and learning disability services are provided by Oxford Health NHS Foundation Trust (OHFT) with one location registered with the CQC in Wiltshire: Cotswold House. The child and adolescent mental health unit based at Marlborough House has a 12 bed inpatient facility for Wiltshire, B&NES and Swindon primarily, although now a nationally commissioned resource, and six beds in the adolescent unit. The trust also operates a children's and adult's outpatient eating disorders service.

Wiltshire was part of the joint Care Quality Commission (CQC) and Ofsted safeguarding and looked after children's (SLAC) inspection program in March 2012. The safeguarding inspection judgement for 'Contribution of health agencies to keeping children and young people safe' was assessed as 'adequate'. The looked after children inspection outcome judgement for 'Being Healthy' was also assessed to be 'adequate'.

Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from young people and carers;

A young mother told us “XXX was a great midwife though I feel a bit left to it since. The midwife helped me through a lot, really believed in me. Overall, all health staff have been pretty good really and have helped.”

A young person who is supported by a multi-agency team through the common assessment framework (CAF) told us, “Things are a lot better now at school. I can talk to the school nurse about being scared about going into classes and she talks things through with me. They don’t listen at the hospital though. They don’t give me a chance to say what I want so that we could discuss it and come to a compromise.”

A foster carer told us that she would be able to make better use of strengths and difficulties questionnaires if she understood their purpose and how they can be used to benefit the child.

A parent of a child with complex health needs told us that “health appointments can be negotiated and there’s enough notice; she sees many profs and all are flexible and friendly. She has had good continuity of care from paediatrics and specialists. The health care co-ordination role is clear; the social worker is involved and has taken steps to become familiar with her needs.”

We heard:

How feedback from new mothers on the maternity ward at Salisbury District Hospital has helped make improvements to services. An example being; staff ensuring mothers have privacy when difficult issues are discussed. One mother told us that she really valued being given this privacy as the ward is very open.

That the help given by health professionals is greatly valued. “Health work is good”. Health staff are respectful towards young people and usually offer choices about times and locations of appointments where it’s possible.

Praise for some diligent work by health professionals to support young people, and of work with carers to secure specialist services or additional help.

That children benefit from a local scheme operated by a large supermarket to donate eggs to children centres. Families can receive a dozen free eggs per week which is encouraging children to eat healthily.

The child's journey

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

1. Early help

1.1 The Wiltshire Safeguarding Children's Board (WSCB) business plan promotes increasingly integrated working and early help for children and families in Wiltshire. This is seen in increasing use of the common assessment framework (CAF) in assessing and securing early intervention to meet the additional support needs of children.

1.2 Early help work led by health staff is increasingly focused on safeguarding children and securing improvements in children's health and development. Midwives at Salisbury District Hospital identify risks at an early stage using comprehensive pre-birth assessments and effectively safeguard mothers and unborn babies. There is a robust approach to ensuring that non-attendance at appointments is followed up. While there is no multi-agency maternity liaison group to discuss risks to unborn babies and vulnerable women, supervisor midwives meet monthly to discuss individual cases of concern and develop complex care plans. Community midwives meet regularly with health visitors to discuss vulnerable mothers-to-be in their area. Colocation facilitates this and helps to ensure professionals are well briefed about issues that may affect the health and well-being of unborn or newly born infants. We saw case examples where this had been effective in identifying safeguarding risks to unborn babies and providing early support to reduce risk.

1.3 Women with mental health needs can access perinatal mental health services at universal and specialist levels. In patient accommodation within the county is limited however and may not be available to all those who would benefit from this level of support. Women also have access to units in surrounding areas, but this would often entail travelling significant distances. We heard about very good continuity of support that helped a young woman with existing mental health needs throughout her pregnancy.

1.4 Handover arrangements between midwives and health visitors are effective in the main, although we heard of some inconsistencies. We heard about some effective partnership work of health practitioners and the network of countywide children's centres to support families. We also saw a number of cases where early help co-ordinated by Great Western community health staff has resulted in improved parenting, beneficial health outcomes for the child and a reduction in risk.

1.5 Development of compatible information systems across health agencies and locations has been slow. Community midwives and hospital maternity services at Salisbury have no shared information system; community midwives having paper driven systems only. This results in lost service capacity as midwives have to convey documents in person and complete duplicate documentation. The risks of vulnerable women and babies falling through the net or delayed identification of vulnerable families who move between areas are increased therefore, particularly given existing capacity pressures within the service. There is some progress in developing information systems however. GWH health visitors and school nurses are implementing a team approach to a secure NHS.net communication with other health providers. This will enable them to share and receive information about vulnerable families and children. Those GP practices using a common system described the benefits of being able to track families and children across the county and check medical histories, particularly where they have concerns.

1.6 Early community mental health support for families is being strengthened with additional consultation forums for health visitors, as part of the development of the infant mental health 0-5 year's pathway. This will offer health visitors, as the lead professional, the opportunity to consult twice monthly with specialist CAMHS practitioners. Meetings will alternate across the north and south of the county with the objective of developing health visitor practice in providing effective early support.

1.7 Where risks to the health, safety, development and wellbeing of children are identified across health services, we have found timely and appropriate follow up to ensure the child's health needs are met, particularly among health visitors and school nurses. The early intervention for psychosis service (EIPT) is effective in facilitating young people's access to psychiatric services at the early onset of symptoms and numbers of referrals to the service are increasing.

1.8 Access to health professionals out of hours is good for those who require an urgent response; examples being the 24/7 mental health outreach service for children and adolescents, (OSCA), for CAMHS assessments and extended hours rosters for consultants in the accident and emergency department at Salisbury District Hospital.

1.9 At Salisbury District Hospital we saw good work on individual cases, and A&E staff are effective in identifying children who may be at risk. However, the named nurse's capacity to cover the safeguarding and paediatric liaison roles is overstretched, reducing the provision of safeguarding supervision to staff (see recommendation 9). Risk identification at the minor injuries unit (MIU) in Trowbridge is less well secured, with staff trained to level 2 rather than level 3 which would be more commensurate with their role and the range of presentations coming to the unit. Many adults attending MIU have children living within their household who may be affected by issues involving the adult presenting for treatment. We saw case examples where children's safeguarding issues had not been fully considered. (see recommendation 6.1).

1.10 We saw examples of effective communication and co-operative working between CAMHS, social care and schools resulting in good, early support to children showing early indications of need or heightened risk. An example being a teenage girl with chronic pain syndrome and anxiety who was frequently absent from school. Effective specialist intervention and partnership working, that was both sensitive to the child's needs and responsive when these changed quickly, has enabled her to attend school more regularly, self-managing her condition to a greater degree. The 'Inside Out' programme for years 8-9 to address issues of self-esteem and health in schools is a positive development.

1.11 Young people can have timely access to a specialist drug and substance misuse service Motiv8, which offers flexible access and good availability of support. Hospital admissions of young people with drug problems have been successfully reduced and the current area of focus is alcohol misuse. Very flexible arrangements support young people who are transitioning to adult services. Increased joint working to further strengthen support to young people during this transition period is currently under discussion. The Substance Use Screening Tool (SUST) is not being used consistently across the health community to assess individual young people's level of need and this may contribute to low numbers of referrals to Motiv8 from health. Opportunities to forge links for young people presenting with drug and alcohol issues at Salisbury District Hospital's accident and emergency department may also therefore be missed. There is good joint work through a drug and alcohol liaison worker at Salisbury District Hospital focused on those attending A&E who may or may not be later admitted to hospital (see recommendation 10.1).

1.12 The adult alcohol and substance misuse service, commissioned by the CCG from Turning Point, offers a good range of responsive and readily accessible services around the county. Effective services for families include support groups, 1:1 sessions and a residential parenting programme for families with children aged 7-8. Turning Point also run an 8 week evening programme attached to the detox centre and pay travel costs for families. These services support parents well, with further developments planned to help increase parents' capacity to care for their children while accessing treatment and thereby reduce safeguarding risks. A programme of parenting courses is due to start shortly and funding is being sought for a crèche to assist parental engagement in treatment. Substance misuse services describe the Hidden Harm agenda as becoming more embedded. Hidden Harm workers commissioned by public health are a useful resource highlighting issues and concerns in families and ensuring these are addressed across the partnership.

1.13 Community health practitioners working with minority groups within military communities demonstrate a high level of understanding and sensitivity to issues of diversity. However, in most health services there is poor identification of ethnicity, religion and culture. Diversity is therefore not generally well reflected in the delivery of services. Managers in CAMHS acknowledge there is more to do to ensure accurate recording of ethnicity and cultural issues and how these may impact on mental health and parenting (see recommendation 8.2).

1.14 A sexual health safeguarding policy is well established and young people can readily access high quality and flexible sexual health services. Eighty-four percent of GP practices have been trained to administer long-acting reversible contraception (LARCS). An already sound approach to risk assessment is being further strengthened with the introduction of a new scored tool to be adopted across the whole service. CASH clinics cannot currently access individuals NHS numbers which can inhibit the service's ability to identify young people known to be at risk. Although the CASH clinics currently use a generic risk assessment tool for both adults and children, managers are looking at how the new tool can be incorporated to further strengthen the existing system and ensure a consistent risk assessment model across all sexual health services. We saw an example of one young person who received an effective and supportive CASH service on her first visit resulting in her following their advice and returning for pregnancy testing and further service.

1.15 The *No Worries* brand for contraceptives and sexual health advice is well known among Wiltshire's young people and is trusted. There are eighteen *No Worries* practices across Wiltshire where nurse led clinics offer open access services to young people, one example of good practice is that of a Trowbridge surgery which offers a *No Worries* service six days a week. Young people can text a mobile number for emergency sexual health support and every young person accessing the service has to give their mobile number. This is then notified to the sexual health nurse, based in public health, who contacts all under 16s as part of effective risk assessment and child sexual exploitation prevention. The nurse usually carries out the risk assessment over the telephone. This successfully engages 95% of the young people she contacts. The sexual health nurse has applied for access to social care's client information system in order to facilitate her risk assessment of young people accessing the contraception and sexual health service

1.16 Work on child sexual exploitation (CSE) in Wiltshire is at an early stage. The named nurse for safeguarding at Salisbury District Hospital is part of a working party set up to identify hot spots of risk in the area, identifying where vulnerable young people hang out and could become targets for perpetrators. The sexual health nurse and the public health lead for sexual health attend the CSE task and finish group and the sexual health lead also sits on the Wiltshire risk management panel.

1.17 Mental health services at tier two and three are more cohesive since the transfer of primary CAMHS (tier two) from the local authority to OHFT which also operates the CAMHS tier three service. As a result, young people move more easily between these services, receiving the most effective support as their needs change or improve due to successful intervention.

A looked-after child living in a care home was assessed as needing tier 3 mental health intervention from CAMHS. Intensive work with a psychologist had positive results and risks of the young person self-harming were reduced. The young person is now receiving a stepped down service of six sessions with primary CAMHS.

2. Children in Need

2.1 There is good multi-agency commitment to working through the common assessment framework (CAF). Increasing numbers of families are supported in this way as a result of multi-agency training and provision of CAF co-ordinators. Health practitioners are increasingly leading the co-ordination of CAFs for vulnerable families and children in need. A CAF is routinely undertaken for young mothers who are under 18 years according with the established pathway. Completing CAFs is relatively new for the midwifery service and is yet to be established practice across the service. We saw one example of an adult mental health practitioner attending a TAC. However, there was no clear identification of the practitioner's role in the CAF and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) managers acknowledge that practitioners are not as involved with CAF as they would want.

2.2 We also saw case examples of effective teams around the child (TAC) and CAFs delivering good outcomes for children and parents.

A CAF was initiated by a midwife for an expectant mother, who has a learning disability, with her own history of receiving poor parenting as a child. Concerns about her parenting of her two elder children were addressed through an effective TAC led by a health visitor. The eldest child had delayed speech and some developmental delay and continues to receive specialist health service support. The mother was well supported by a range of disciplines to parent her youngest child more effectively, including breast feeding for the first time.

As a result the youngest child has no identified health needs, attends nursery regularly and is not subject to any intervention.

2.3 Feedback received by community health services indicates that families feel more supported by effective multi-agency working. Some families feel the stronger intervention of a CAF is more than they would have expected, but most do come to recognise the benefits of this on family life and the well-being of their children. As a result of being able to identify positive outcomes from the CAF, community staff are increasingly embracing this way of working.

2.4 In most health services child non-attendance (DNA's) are responded to promptly, and DNA policies are in place. Notification goes back most frequently to health visitors where they are the key professional working with a family. Community health practitioners are effective in working proactively with families where children are likely to miss key health appointments. Health visitors arrange to be copied into appointments for these children. This increases the likelihood of the child attending key appointments to meet identified health needs and for the attainment of beneficial health and wellbeing outcomes.

2.5 However we did find some inconsistencies in this area; in one case a DNA at the paediatric clinic had not been notified back to the health visitor as lead professional although the child had been identified as a child in need. This DNA was only acted upon when the health visitor, following up on a number of DNAs across a number of health services for this child, checked with the consultant paediatrician (see recommendation 11.1).

2.6 A new approach to risk assessment in the community health service was introduced in July 2013. However, this is not yet embedded in practice and we did not see this well demonstrated in case recording or in our discussions with practitioners. Health visitors and school nurses do not evaluate their detailed observations to clearly identify the level of safeguarding risk to the child. Neither do they make clear plans about what needs to change in a family to reduce risk. The outcome column of the record is frequently left empty or used for a variety of recordings by health visitors and school nurses such as tasks to be carried out. As a result, risks to the child may not be clearly identified and plans and objectives to deliver good outcomes for the child may not be sufficiently robust or effectively communicated to other professionals or managers within the service. There is some confusion in community health services about the use and value of keeping chronologies on case records where there may be child protection issues and how these may impact on delivering the optimum service for the child. While we saw some good chronologies, they are not routinely present on records. One case chronology set out dates of health visitor activity rather than significant events that may have an impact on the child's health and well-being.

2.7 A recording group is currently reviewing the community health's service approach to record keeping. Health visitors spoken with acknowledge they are not clear how best to use recording and find the current template confusing. School nurses' informal contacts with children known to be subject to children in need or child protection plans are not always recorded on the child's record. One school nurse we met recognised the need to do this from a learning event and has changed her practice as a result ensuring an on-going risk assessment record and progress tracking for that child (see recommendation 2.1).

2.8 Health visitors take positive action to ensure the effective handover of families to other locality health visitor teams when families move. Priority is given to families on enhanced health visitor support. Lack of IT and the range of systems make the tracking of children and their families who move between different health teams and services difficult, but staff work hard to track children and use local intelligence well (see recommendation 8.4).

In one case where a family with vulnerable children moved areas within the county, a large CAF meeting was held involving the existing CAF team and the new CAF team to ensure an effective handover.

All professionals were able to identify that over the summer, the child's health and wellbeing had improved.

2.9 Community health staff assess children's emotional health using a range of tools in addition to the standard health check tool which is focused more on physical health. These are effective in engaging the child in the process. However, awareness and use of particular tools is localised to specific teams and not widely shared to promote consistent good practice.

2.10 CAMHS hold care programme approach (CPA) meetings at locations preferred by the young person. Use of face-time for mental health consultations encourages young people to engage.

2.11 The inclusion of a CAMHS manager in the Gateway panel is facilitating prompt identification of cases where early support may reduce levels of risk within families close to child protection thresholds. The Gateway can link families to the intervention support of the Families First service. This is highly valued for its hands on support to secure improvements for children in chaotic families. However, some vulnerable parents and their children are struggling to cope once this short intervention ends. The proposed development of an early intervention programme locally will strengthen the range of preventative supports and widen the early help offer.

2.12 We saw effective transitions of young people receiving support from the Early Intervention for Psychosis team (EIPT) moving from CAMHS to the adult mental health service. The same care co-ordinator was maintained but the young person moved under the care of an adult consultant. This was achieved seamlessly as all the young person's care stayed within EIPT.

2.13 The approach of adult mental health in inviting social care to participate in discharge planning for a parent whose child may be subject to CAF or child protection plans is variable and dependant on individual workers (see recommendation 5.1).

A mother with learning disabilities and cerebral palsy with two small children was well supported by an effective team around the child. When the mother fell pregnant very quickly after the birth of her first child, a Common Assessment Framework (CAF) was put in place and a referral made to Gateway. A Families First worker was appointed and objectives set with the parents for the preparation for birth, child care and housekeeping. With effective and sensitive support from the health visitor, Families First, the children's centre and community nursery nurse, positive changes have been made and the babies are doing well.

3. Child Protection

3.1 There is good recognition by most health professionals of safeguarding thresholds and their professional accountabilities for keeping children and young people safe. The escalation policy is being used effectively and staff are clear on when it should be invoked.

3.2 Where practitioners are making safeguarding referrals to social care, they are not always clearly articulating those concerns in relation to the actual risks to the child. We saw several examples in adult mental health of poor articulation of the risks to a child in a safeguarding referral to social care with the emphasis and detail focused on the assessment of parental mental health. Health visitors also do not always articulate their safeguarding concerns about particular children sufficiently clearly when making referrals to social care (see recommendation 3.1).

We reviewed one case where a health visitor had discussed concerns about a case in supervision and made a safeguarding referral which had been rejected as not meeting the threshold. The health visitor reframed the referral, setting out the impact of parental behaviour on the health and wellbeing of the child more clearly and resubmitted it. This was then accepted by social care as meeting the threshold for help.

The risks to the child remained the same but as a result of a more clearly articulated referral; the child gained the appropriate level of support.

3.3 General practitioner engagement in child protection is underdeveloped and primary care safeguarding practice is a priority area for improvement. Community health practitioners report finding it difficult to liaise effectively with GPs on cases where a child is known to be vulnerable or subject to child protection plan, as GPs do not always respond to requests for information from health visitors and school nurses. They are getting better at sending reports to child protection case conferences but rarely attend. The GP case conference reports that we saw contained basic information only and little that would inform the case conference of the parenting capacity of the adult, or the child-parent interaction observed at the practice. To date there has been no partnership exploration of alternative arrangements to facilitate GP participation in case conferences such as telephone or video conferencing or different scheduling of conferences (see recommendation 1.1).

3.4 The named GP acknowledges that the safeguarding agenda has not yet fully developed although primary care has started to make some progress. Although GPs are taking part in level 3 safeguarding training and most are keen to improve their practice, they lack confidence in how to respond in relation to safeguarding children and practice is coming from a low base. In the practice we visited, the practice manager has done a very good job in making child protection and safeguarding processes more readily available to the practice GPs. This initiative has the potential to be developed further to improve all GP practices in being better equipped to best safeguard children in their area.

3.5 Maternity staff at Salisbury District Hospital are skilled in identifying risks to unborn babies and make prompt referrals to social care, understanding the value of early help. Despite midwives notifying as soon as concerns were identified, in one case at nine weeks gestation, we saw several cases where initial child protection conferences were convened late into the pregnancy for example 32 and 37 weeks. This risks babies being born before plans are in place and is contrary to research about achieving good outcomes. A new unborn baby safeguarding policy is in draft with the potential to support more effective multi-agency working in this area, but its status and timescale for implementation is unclear (see recommendation 7.1).

3.6 Accident and emergency staff at Salisbury District Hospital demonstrate a good awareness of potential indicators of abuse against children and follow appropriate procedures to keep children and young people safe. Safeguarding leads are vigilant in using and overseeing a labour intensive paper driven system; information systems being currently unable to collate safeguarding issues or identify patterns of individual children's presentations as they arise in A&E. There is more to be done to develop data about hidden harm, ensuring that more children at risk of hidden harm are identified, with A&E being a key location. The paediatric liaison role is effective in reviewing child attendances for safeguarding issues, although this role only operates two days per week. The named nurse responds to concerns raised by staff on other days. Staff leaders meet regularly to review child and young person presentations and use this forum to flag them up as practice learning issues.

3.7 Frontline health practitioners such as health visitors are routinely participating in strategy discussions. Their knowledge of the family and health and wellbeing of the child is making a significant contribution to decisions about the level of intervention most likely to result in the best outcome for that child.

3.8 Most health staff are appropriately engaged in all aspects of child protection activity. An administrative hub is effective in facilitating the attendance of community health practitioners (health visitors and school nurses) at key meetings and conferences for children. There is a lack of clear planning and objective setting in GWHFT community health services when working with children subject to child protection plans. The role of the health practitioner in protecting the child is not always clearly recorded. Practitioners are not consistently able to articulate their child protection role in relation to individual children and as a result, key elements of the child protection plan may not be delivered and the child not be fully protected (see recommendation 2.1)

3.9 GWHFT practitioners give verbal recommendations to conferences but these are not always clearly set out on the child's community health record. Where siblings within a family are subject to child protection plans, plans and professional reports submitted to child protection conferences are not always placed on each child's record, contrary to local policy. This is an area for development as each individual child should be subject to separate recording. Some community health practitioners make appropriate chronologies of significant events in the life of the child in the front of case records, using these to inform their work with the family. In one case reviewed however, the chronology was mis-used to record school nurse activity only rather than significant life events of the child (see recommendation 2.1).

3.10 Adult mental health advance directives give appropriate consideration to how children will be cared for if a parent requires an in-patient admission. However, there is no operational protocol about how workers ascertain social care involvement with the adult or any children. Relapse indicator lists used by adult mental health are good practice. However, these do not give sufficient consideration to how deteriorating mental health may impact on the adult's ability to effectively parent their children nor do they include consideration of deteriorating parenting as an indicator of mental health relapse (see recommendation 2.1).

3.11 Identification of children subject to child protection plan on adult mental health case record front-sheets is inconsistent and details such as date of birth are often lacking. This has significant potential for risks to children being missed. In adult mental health, in cases where there are children subject to child protection plans, the social worker is not routinely invited to participate in the discharge planning for the parent when they are receiving in-patient treatment. Therefore child protection issues and the adult's parenting capacity to ensure the wellbeing of the children may not be fully considered (see recommendation 5.1).

3.12 Similarly, we saw variation in how effectively CAMHS and adult mental health work together in cases where both services are involved.

A parent was admitted as in-patient while continuing to send suicidal texts to her daughter. Even though the mental health of one was clearly having a detrimental effect on the emotional health of the other and there was a high level of interdependency, there had been no liaison between CAMHS and adult mental health.

No multi-agency professionals meeting had been convened to look at the family jointly.

3.13 A nationally recognised exemplar protocol with Wiltshire Constabulary is in place, governing children and young people held in custody under s 136 of the mental health act. As a result, numbers of young people taken into custody are very low. Avon & Wiltshire Partnership Trust is now allowing 16-17 year olds access to the Salisbury AWP unit and work is in train to resolve the lack of provision for under 16s. These are very positive developments in response to the findings of the 2012 Ofsted/CQC inspection.

3.14 In a case where a young person had been identified as being at high risk of child sexual exploitation and had been very hard to engage; determined but sensitive young person-centred efforts had resulted in significantly reduced risk. The young person was able to see how the intervention and support had helped her to protect herself and to re-enter fulltime education.

A large family was living in a shared environment with extended family. There were few boundaries and the younger children were identified as being at risk and placed on child protection plans. Effective multi-agency intervention including support to move home establishing a safer and more settled environment, resulted in reduced risks to the children. The emotional health and well-being of the children improved as a result and they were able to express feeling safer and happier.

The children were moved from child protection to children in need plans and continue to do well.

4. Looked after Children

4.1 Some looked after children have improved health and well-being as a result of effective, and often imaginative intervention. This is not true for all the looked after children we have reviewed and overall the picture is very disappointing.

4.2 Social care is not routinely sending prompt notifications for initial health assessments (IHA) as soon as children are taken into care. In a case where a baby became a looked-after child at birth, notification to health for an IHA was not sent until 12 working days after birth. As the baby remained in hospital until going to foster care seven days after birth, the reason for this delay is not clear. Asylum seekers in particular have experienced months of delay before their health is assessed. A key performance indicator has been brought into the performance data set from next year to increase monitoring rigor (see recommendation 9.1).

4.3 We reviewed initial and review health assessments undertaken within the last 12 months. The quality of initial health assessments undertaken by a range of clinicians including registrars, staff grades, associate specialists and consultant paediatricians within GWHFT and Sirona is inconsistent, with some we saw being of very poor quality. One paediatric consultant in Swindon sends a typed letter for the IHA rather than the required reporting forms as outlined in the locally developed process and reporting form. This can cause additional delay in addressing assessed health needs of the looked-after child. This is despite several requests to paediatricians by the looked-after children's nurse to ensure they are completing the correct documentation (see recommendation 9.1).

4.4 Asylum seekers as looked-after children are not being well served by health. Some initial health assessments for asylum seekers are very poor quality, with no evidence of understanding or evaluation of their experiences as asylum seekers and the impact this may have on their health and wellbeing. In the case of one asylum seeker, religious and background culture was identified under emotional behaviour. There is no routine peer review quality assurance of initial health assessments. Where the looked-after children's nurse identifies issues about quality, these are raised with the designated nurse who addresses them with the clinician. A multi-agency peer review audit of the quality of health assessments was carried out in October 2013 led by the designated doctor and designated nurse for looked after children (see recommendation 9.1).

4.5 The looked-after children's nurse demonstrates significant commitment and effort and has worked hard in trying to deliver all aspects of the role in a service with a significant improvement agenda. Health reviews undertaken by the looked-after children's nurse are child centred and she is diligent in engaging young people wherever and however they wish. Strengths and difficulties questionnaires are being completed with young people, however they are not consistently returned to the LAC specialist nurse therefore losing the opportunity for these to inform health assessments (see recommendation 9.5).

4.6 The voice of the child is reflected within the health reviews undertaken by the looked-after children's nurse and issues of diversity and family circumstances are recognised. We are told the young person receives age appropriate health information, but we have not seen this. The looked-after children health records are not well ordered making it difficult to navigate and track the child's journey chronologically.

4.7 Health reviews are episodic in nature with no clear connection between them. Where specialist services are working with the child such as CAMHS or speech and language therapy (SALT), copies of progress reports are not routinely copied to the LAC Nurse and therefore do not inform the subsequent RHA. Health plans with accountabilities are identified following health reviews, although some timescales for delivery are loose and not measurable (see recommendation 9.1).

4.8 The looked-after children's nurse is not routinely invited to statutory looked-after child reviews and therefore unable to effectively attend those of priority with significant health needs. CAMHS clinicians routinely attend statutory looked-after child reviews and give a verbal report. As details of this verbal report are not shared with the looked-after children's nurse, the subsequent review health assessment is not fully informed. Not all GPs contribute to the health assessments or reviews for looked after child in their practice although they receive copies of the health plan. As a result of these gaps in provision and information sharing, the meeting of looked-after children's health needs cannot be fully assured (see recommendation 9.1 and 1.3).

4.9 We found that GPs have a low level of understanding about looked after children policy and guidance, expectations in practice and their responsibilities. Priority has been focused on increasing their knowledge of early help and safeguarding. Expectations about GPs' contributions to review health assessments are not well understood. Changes of parental responsibility, address and other key events for a looked-after child or child subject to a child protection plan, such as contact arrangements are not routinely shared with GPs or identified as important safeguarding issues within the practice (see recommendation 1.3 and 1.5).

4.10 Targeted support, information and advice is being delivered to foster carers and improving their parenting capacity for individual children with challenging behaviour; Some foster carers told us they have found it hard to access health-related training more generally but that a new programme was about to start.

4.11 The OSCA mental health service responds promptly to referrals regarding hard to engage young people who are looked after, retaining them on their caseload while continuing to encourage engagement until they reach adulthood. There are sensitive and good arrangements for young people who have been looked-after children to continue to receive help from Motiv8 up until they are 24. Transitions from CAMHS in to AMH are not always smooth and operational managers acknowledge a continual need to audit the effectiveness of the protocol. Young people and their carers are concerned about and affected by the lack of services to support mental and emotional needs which fall outside adult services thresholds, and leaving young people at risk of deterioration at a crucial time in their lives (see recommendation 4.1).

4.12 There is effective support to care leavers from mental health where they are already engaged with the young person when they leave care. An example being a care leaver struggling with mental health issues while in independent living accommodation. The multi-agency support to this young person is effective in working to her wishes, while helping her to understand their level of concerns and in gaining her agreement to additional support.

4.13 Care leavers lack an effective service to support and promote their health and well-being, and we have seen no clear progress since the 2012 Safeguarding and Looked-after children inspection (SLAC). Health summaries are not yet in place on case records and we saw a case where a young person recently left care with nothing more than a list of immunisations. A health history template was agreed in July 2013 but is planned for implementation in December 2013 as part of a health passport planned to be given to all care leavers. The passport will also include health information and advice.

A 17 year old male asylum seeker became a looked-after child in February 2013 and placed out of area in Swindon B&B in March. He missed his initial health assessment appointment which was in July. Although he kept the rearranged appointment, no interpreter had been booked so a further appointment was given for August, six months after he became looked-after. He was not registered with a dentist and his immunisation status was not followed up with his GP. The looked-after children's nurse was not informed of this out of area placement. On the review of the case, prompt remedial action was taken to ensure the young person had a full health review and all his health needs have now been addressed.

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 Partnership working is good. Partners describe an increasingly mature dialogue between organisations resulting in more effective and prompt resolution of issues. The establishment of a multi-agency safeguarding hub (MASH) from January 2014 with safeguarding advisors working in community health teams will further strengthen the partnership's safeguarding arrangements. To continue to build relationships and improve understandings between services, mental health act awareness training has been opened to social care practitioners.

5.1.2 The lead commissioner for children has strengthened the children's service profile across the partnership and with both adults' and children's service providers. The CCG is providing effective leadership.

5.1.3 Looked-after children's health is commissioned by public health within the local council. In the past twelve months, designated leads for looked-after children's health have been appointed in line with statutory guidance and accountable to public health. While this establishes a stronger governance infrastructure, we have not seen sufficiently strong leadership and governance demonstrated through the attainment of improved outcomes for looked after children and young people (see recommendations 9.1 - 9.5).

5.1.4 Although co-operative working and communication between OHFT's CAMHS service and AWP's adult mental health service has improved over the past twelve months, there is more to do to ensure consistent effective joint practice.

5.1.5 The NHS England Local Area Team is developing its primary care leadership role with significant support from the designated nurse, but there is a long way to go. Health is well represented on the safeguarding board (WCSB) although the relatively new named GP does not sit on the board and therefore does not benefit from board discussions which would help develop his leadership role. There are currently no arrangements for the named GP to meet regularly with GP practice safeguarding leads (see recommendation 1.4).

5.1.6 Providers describe the designated nurse as completely engaged with them in a supportive yet challenging way. She is very accessible and advice given is sound. She is instrumental in delivering high quality bespoke training across services and has led the safeguarding improvement agenda very effectively. Evidence of leadership from other designated leads for both safeguarding and looked after children is much less well demonstrated (see recommendations 1.4, 9.2 and 11.1). In recognition of the current designated nurse's new, wider role as CCG associate director of adult & child safeguarding, a new designated nurse for safeguarding has been recruited to ensure strategic arrangements continue to be robust. We saw some good and effective work by named professionals to ensure effective safeguarding practice across frontline services. Named safeguarding lead practitioners across services are supportive and accessible to staff and regarded in most service areas as leading service improvement.

5.1.7 Increased investment has been made in community health services to deliver the 'Call to Action' programme. Health visitor hours have been increased across the county for team managers to deploy to best meet local needs.

5.1.8 Managers and team leaders in GWHFT told us that the maternity liaison pathway is not working consistently effectively but is variable and dependant on individuals. The dispersed services and lack of linked information systems are constraints to communication. The maternity liaison committee involving community health team leaders and senior midwives is examining information on which locality pathways are not working well. The maternity liaison committee feeds back to locality team leader meetings and the pathway is being followed more effectively as a result, but there is still work to do to assure consistency across the county.

5.2 Governance

5.2.1 The safeguarding improvement board put in place following the 2012 SLAC inspection has helped to drive the pace of improvements to safeguarding arrangements across health services. The CCG Quality and Clinical governance committee is effective in overseeing the quality of service delivery. The CCG has developed safeguarding standards to be used in all contracts for any provider both statutory and voluntary, which has contact with children and young people. This contract requirement includes providers delivering services to adults who may have contact with children and young people. Providers are required to audit their compliance with these standards using a standard tool and use the findings as the basis of the provider's annual report. The designated nurse is also providing bespoke safeguarding training to contracts management staff in order to build greater rigor into contracts monitoring.

5.2.2 Additional investment from the CCG to upgrade named safeguarding practitioner posts and recruit permanent named safeguarding clinicians has strengthened governance arrangements. This has included a permanent named doctor and an upgraded named nurse post for CAMHS.

5.2.3 The practice of the designated nurse and named GP in partnership with the NHS local area team (LAT) undertaking joint visits to GP practices is a good governance and practice development model. This partnership engages practices in reviewing actions and decisions that have resulted in sub-optimal safeguarding practice, helping the practice to identify learning and implementing a subsequent action plan. This model is being adopted by the LAT across its' geographical area although its impact in delivering sustained improved safeguarding practice has yet to be demonstrated. The LAT is planning to dip sample practices to check that actions identified through these practice based and other learning events have been taken and practice improved as a result. It is early days for the LAT which is being supported in developing its governance role by the designated nurse.

5.2.4 Quality assurance of the health service to looked-after children is underdeveloped (see recommendation 9.1). Performance on delivery of initial health assessments (IHA) has improved from 4% in 2012 and to fifty per cent achieved within the twenty eight day timescale. The rate of progress has varied across organisations and all four organisations involved need to be committed to delivering timely assessments. The annual looked after children's health report was recently presented to the safeguarding operational board, children in care commissioning group, corporate parenting panel and WSCB. The report includes information on a range of outcomes for LAC including timeliness of initial and review health assessments, immunisation uptake dental checks and substance misuse. Though the report includes an improvement plan built around the NICE quality outcomes for LAC it does currently not include clear targets related to measurable outcomes. Key performance indicators being brought into the performance data set from next year will increase monitoring rigor.

5.2.5 The multi-agency looked-after children's health partnership meets bi-monthly bringing together the providers of services for looked-after children. This group examines areas for development and ways of improving the health care of looked-after children, reviewing what has been learnt and how practice has improved since the last meeting. Whereas, this group has overseen a number of developments with the potential to improve the service, some have yet to be implemented or have made little impact to date, such as health histories.

5.2.6 Performance in health of the delivery of CAF is improving. A monitoring mechanism is in place to record the number of CAFs with a feedback loop to commissioners and a KPI being put in next year when the increase in numbers is expected to be demonstrated. Governance of the adult substance misuse service has been made more rigorous: the public health team in the council, on behalf of the Community Safety Partnership, having commissioned a single provider, now responsible for delivery of the whole service.

5.2.7 The transitions protocol from CAMHS to AMH has been strengthened in relation to safeguarding. Managers and commissioners regard the protocol as effective but transitions from CAMHS in to AMH are not always smooth and managers acknowledge a continual need to audit it. Oxford Health Foundation Trust are currently reviewing all young people who are apparent suicides across the provider's whole geographical patch to identify risks and use findings to inform transition pathway development. The findings of the review will be reported back to all the relevant CCGs.

5.2.8 Safeguarding leadership and governance arrangements at Salisbury District Hospital have been reviewed and strengthened arrangements including a safeguarding committee are being implemented.

5.2.9 More rigorous outcome measures are being introduced in CAMHS to better monitor the impact of intervention for individual young people and evaluate effectiveness of overall service delivery. Since the transfer of the primary CAMHS service from the local authority to OHFT the service has become more effective. Performance targets have been set and stronger governance arrangements have driven up performance. More young people are being seen by primary CAMHS, including 0-5 year olds whom they did not see previously. Interventions are now more planned and the CAMHS and primary CAMHS managers allocate cases jointly so that services are targeted more effectively to address the early mental health needs of children and young people.

5.2.10 The adult mental health service does not have a robust approach to the quality assurance of its safeguarding arrangements. Clinical risk panels and a governance group for safeguarding are in place and we were told that improved data on performance is being developed, along with a stronger approach to governance of safeguarding practice.

5.2.11 Supervisory staff with quality assurance responsibilities told us that they are required to undertake case record audits as part of their child safeguarding governance role, but they are unclear what good looks like and do not feel well equipped for this role.

5.2.12 In some services, children and young people are encouraged to regularly share their views and experiences in evaluating the quality and impact of health services but this is not a universal approach. As such we are unclear as to the extent to which services are responsive to, developed and commissioned to best address the feedback and wishes of children, young people and families (see recommendations 8.1 and 9.6).

5.3 Training and Supervision

5.3.1 All stakeholders recognise that there is more to do to ensure that staff are fully equipped for their roles in safeguarding or in supervising the practice of others. Bespoke safeguarding training is being developed for contracted providers by the designated nurse.

5.3.2 We identified a case where the Specialty Doctor Consultant working under the designated doctor demonstrated a lack of understanding and appropriate consideration of diversity issues in working with asylum seekers and variable levels of understanding of the expected standards in undertaking health assessments for looked-after children (see recommendation 9.2 and 9.4).

5.3.3 We also found that frontline staff at minor injury units (MIUs) are not trained and supervised to appropriate levels of safeguarding competence to ensure they can safeguard and promote the health needs of children. Reception staff, who undertake a key safeguarding role in taking initial details from patients and observe adult and child behaviours and interactions, have only received level one training; none of the staff or front line managers are skilled to level 3 competencies. Group supervision was initiated at the recent team development days and group supervision is now provided on a bimonthly basis. 1-1 informal supervision is provided on an ad-hoc basis and is accessed on a regular basis. 1-1 formal supervision has not been introduced. This needs further development to sufficiently equip MIU staff to protect children and young people effectively and although we saw some good practice examples, we also saw a number of case examples where safeguarding issues had been missed (see recommendation 6.1).

5.3.4 The named GP reports that he has had a considerable amount to learn since his appointment in April 2013. He has undertaken level 2 and 3 training and attended a level 4 National Conference aimed at lead safeguarding professionals. In addition he has shadowed the designated nurse presenting training and joint visits to practices have been undertaken to discuss significant safeguarding events and these had provided another opportunity for learning. General practitioners are currently continuing to access training sessions provided by the designated nurse and named GP, arrangements are currently being developed to ensure on-going training sessions in 2014. All practices have a safeguarding lead but their skills in driving improvements are not yet developed. While appraisals of GPs are in place, these are not yet sufficiently robust to drive improved safeguarding practice in primary care (see recommendation 1.4).

5.3.5 Community staff attend serious case review (SCR) learning events and feel well supported by managers to deliver improved service delivery as a result. A health visitor team leader and practitioner identified the learning event "A day in the life of a child" as having a positive impact on practice with practitioners being more focused on the dynamic of the whole family and the resultant experience of the child as a result.

5.3.6 Supervision arrangements are variable with work done in each service to make improvements. GWHFT has introduced a new supervision model to strengthen arrangements in health visitor and school nurse services and bring the services in line with good practice. GWHFT has also introduced an annual safeguarding knowledge and practice audit as part of each practitioner's personal development review. The named nurse at Salisbury District Hospital is significantly stretched as the role has developed since initial recruitment. This has a negative impact on the nurse's capacity to deliver appropriate individual supervision to key supervisory staff. Midwives at Salisbury District Hospital have good daily access to safeguarding advice from a supervisor; however arrangements for formal safeguarding supervision for individuals with high risk caseloads do not meet statutory guidance (see recommendation 6.1).

5.3.7 There is difficulty in recruiting paediatric trained nurses for A&E and Minor Injury Units (MIU), although efforts have been made to skill up general nurses to provide appropriate care. The head of midwifery and named nurse at Salisbury District Hospital have a good understanding of training requirements for the service however, a lack of capacity and staffing pressures make it difficult to release staff from operations to attend training. This is delaying the trust's ability to achieve compliance in safeguarding training expectations although among the paediatric staff, compliance is good. Two thirds of community midwives have now undertaken two day level 3 training which has been the priority whereas progress to ensure all relevant staff complete levels 1 and 2, has seen less progress (see recommendation 6.1).

5.3.8 In both CAMHS and adult mental health, where cases are discussed in supervision, this is not recorded on the patient's case record although this is routine practice in GWHFT community health services. If a CAMHS or adult mental health case is discussed in a team work group meeting, then it would be recorded in minutes and be entered onto patient's record in both services. This practice results in a less complete client record, with potentially key decisions about intervention being missing (see recommendation 2.1). Great Western community health staff receive regular supervision. This is regarded in the service as a priority and is valued by practitioners.

5.3.9 Managers in AWP acknowledge there is more to do to ensure supervision addresses safeguarding issues effectively: the focus to date has been on achieving safeguarding training requirements for frontline staff, although achieving training targets remains a challenge. Caseloads in the adult mental health recovery team are high and managers identify the need to step down adult mental health involvement in cases as appropriate. To this end, Avon & Wiltshire Partnership Trust is about to launch a case load profiling tool to be used in Wiltshire's adult mental health service. This will be used in supervision and is intended to manage caseloads more efficiently and set out safeguarding risks on cases.

Recommendations

1. **NHS England and Wiltshire CCG should work with General Practitioners to ensure that they fulfil their responsibilities in safeguarding children and young people and for looked-after children by:-**
 - 1.1 Demonstrating prompt and effective risk assessment to children and young people within the practice and where risk is identified that prompt and appropriate referrals are made.
 - 1.2 Contributing effectively to child protection conferences by either attending the conference and/or submitting a detailed report on the child and their family to support effective planning.
 - 1.3 Demonstrating clear understanding about looked after children's policy and guidance, and their responsibilities in relation to looked-after children in their practice.
 - 1.4 Developing the leadership role of designated doctor and named GP to best support the delivery of effective safeguarding across services.

2. **Wiltshire CCG with Great Western NHS Hospitals Foundation Trust, Avon & Wiltshire NHS Partnership Trust and Oxford Health NHS Foundation Trust should;**
 - 2.1 Ensure that case recording is comprehensive, setting out the role of the practitioner in child protection plans and reflective of best 'Think Family' practices.

3. **Wiltshire CCG with Great Western NHS Hospitals Foundation Trust and Avon & Wiltshire NHS Partnership Trust should;**
 - 3.1 Ensure that in making safeguarding referrals to social care, practitioners articulate clearly the assessed risks to the health and well-being of the child in order to facilitate decisions about what level of support is needed.

4. Wiltshire CCG with Avon & Wiltshire NHS Partnership Trust and Oxford Health NHS Foundation Trust should;

- 4.1 Review service provision for young people in transition from CAMHS with on-going emotional health needs who are unlikely to meet thresholds for adult services.

5. Wiltshire CCG with Avon & Wiltshire NHS Partnership Trust should;

- 5.1 Ensure that in cases where children are subject to child in need and child protection plans, adult mental health practitioners are fully engaged with relevant partner agencies.

6. Wiltshire CCG with Great Western NHS Hospitals Foundation Trust and Salisbury NHS Hospitals Foundation Trust should;

- 6.1 Review staffing capacity to ensure the workforce profile meets intercollegiate guidance and that staff are trained to appropriate levels of safeguarding competence and receive supervision in line with statutory guidance.

7. Wiltshire CCG with Salisbury NHS Hospitals Foundation Trust and Wiltshire Council should;

- 7.1 Ensure that an effective protocol is implemented to ensure early planning takes place in response to identified risk to protect unborn infants.

8. Wiltshire CCG with Great Western NHS Hospitals Foundation Trust, Avon & Wiltshire NHS Partnership Trust, Oxford Health NHS Foundation Trust and Salisbury NHS Hospitals Foundation Trust should;

- 8.1 Ensure that services are responsive, developed and commissioned to best address the feedback and wishes of children, young people and families.
- 8.2 Ensure that practitioners are knowledgeable and sensitive to issues of diversity and that the provision of health care for individuals is informed and appropriate.
- 8.3 Ensure that child or young person non-attendance at clinical appointments is duly followed up according to established protocols.
- 8.4 Continue to review health information systems to ensure information sharing is effective in protecting children and young people.

9. Wiltshire Public Health with Wiltshire CCG, Great Western NHS Hospitals Foundation Trust, Oxford Health NHS Foundation Trust and Sirona should;

- 9.1 Ensure the delivery of quality assured and effective health services to looked-after children and care leavers.
- 9.2 Developing the leadership role of the designated doctor and designated nurse to provide effective leadership and quality assurance of the health provision for looked-after children.
- 9.3 Review the provision of health services for asylum seekers in the care of the authority.
- 9.4 Ensure that practitioners are knowledgeable and sensitive to issues of diversity and that the provision of health care for individuals is duly appropriate.
- 9.5 Review the use of strengths and difficulties questionnaires or other evidence based tools to monitor the emotional and mental health of looked after young people, facilitating young people's participation whenever possible.

10. Wiltshire CCG and Wiltshire Council with Great Western NHS Hospitals Foundation Trust, Oxford Health NHS Foundation Trust and Salisbury NHS Hospitals Foundation Trust and Motiv8 should;

- 10.1 Ensure that children and young people's misuse of drugs and/or alcohol is consistently assessed and that young people with substance misuse issues presenting to acute health services are appropriately facilitated to access treatment and support.

11. Wiltshire CCG with Salisbury NHS Hospitals Foundation Trust, Oxford Health NHS Foundation Trust and Sirona should;

- 11.1 Ensure that child or young person non-attendance at clinical appointments is duly followed up according to established protocols.

Next Steps

An action plan addressing the recommendations above is required from Wiltshire 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.