This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently.

It provides more detailed evidence and feedback on the findings from the Care Quality Commission’s (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children’s Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: [The joint inspection report](#)

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This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC’s head of national Inspections, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:
Bournemouth is a major coastal resort on the south coast of England. The town has seven miles of beaches and 842 hectares of parks. It is close to the New Forest and the Jurassic Coast, and attracts a large number of visitors, leading to the employment of significant numbers of seasonal and immigrant workers. It has good road and rail links to London, and domestic and international air services from Bournemouth Airport, located in the neighbouring district of Christchurch. (Ofsted, March 2011)
Bournemouth has a population of 165,000 of which approximately 35,000 are below the age of 19. The proportion of school age children in the borough is 15.6%, compared to a national average of 18.7%. In recent years there has been a significant increase in the birth rate, which has led to the need for more early years and primary school places to be created. This trend is projected to continue, with the total population of the borough estimated to increase to 180,000 by 2033. (Ofsted, March 2011)

Commissioning and planning of NHS services and primary care are carried out by NHS Bournemouth and Poole. Bournemouth and Poole Community Health Services currently deliver a range of health services to children and families, such as health visiting and school nursing. Plans are in place as part of the Transforming Community Health Services agenda to transfer these services to a joint arrangement led by Dorset Healthcare University NHS Foundation Trust, with Bournemouth Borough Council as a partner (Ofsted, March 2011).

The Bournemouth and Poole area is served by two hospital trusts, Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Further services, including specialist mental health services, are provided by Dorset Healthcare University NHS Foundation Trust. Services provided by Poole Hospital NHS Foundation Trust, which provides an in-patient unit for children and young people from Bournemouth, were not included as part of this inspection. (Ofsted, March 2011)

1 **General – leadership and management**

1.1 The Change for Children Board (Bournemouth’s Children’s Trust) has representation from all key statutory agencies and the voluntary and community sector. The Local Safeguarding Children Board is a joint arrangement with the neighbouring Borough of Poole. The Board has an independent chair and brings together the main organisations working with children, young people and families in Bournemouth and Poole. (Ofsted, March 2011)

1.2 The partnership has a thorough JSNA, however, this does not identify the LAC as a discreet population and therefore planning of services for this cohort is not based on local need.

2 **Outcome 1 Involving Users**

2.1 There is good use made of feedback from users of services and there is evidence of this feedback influencing future service provision across health services. Examples include the work carried out by the sexual health team with young people to deliver peer education within schools. The Contraception Advice & Sexual Health Service (CASH) has also changed their opening hours to late evenings as well as providing a special clinic for young people who are lesbian, gay, bisexual or transsexual in response to feedback from service users.

2.2 Dorset Healthcare University NHS Foundation Trust worked with children, young people and their families to help shape the new in-patient facilities and also co-designed the website [www.wheresyourheadat.co.uk](http://www.wheresyourheadat.co.uk). The website provides targeted information on emotional health and wellbeing for children and young people.
3 **Outcome 2 Consent**

3.1 The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust do not have a pathway in place to gain consent from young people for a referral to the Young Adults Advisory Service (YADAS) following an attendance at the Royal Bournemouth Hospital’s A&E department where the misuse of substance/s was of concern. This means that the risks, benefits and options for referral are not discussed and explained in a way that the young person is able to understand.

4 **Outcome 4 Care and welfare of people who use services**

4.1 Children who attend the A&E department at the Royal Bournemouth Hospital are mostly seen in a child friendly and appropriate treatment area. There is a dedicated one bedded paediatric area with a small children's waiting room. These facilities are available 24 hours a day, seven days a week. Though the A&E department will see and treat children and young people at the Royal Bournemouth Hospital there are no paediatric in-patient facilities at the hospital and if an admission is required, the individual would be transferred to Poole Hospitals NHS Foundation Trust or to hospitals in Southampton, Salisbury or occasionally Dorchester. There are good working relationships between the two trusts and the Poole Hospitals NHS Foundation Trust provides 24 hour on call rota for safeguarding children advice and assistance.

4.2 The arrangements to safeguard children and young people who attend A&E are adequate. There is a system in place to identify repeat attendance of all children and young people. The A&E unit do not have an alert or flag on their IT system to identify if a child has a child protection plan or if they are looked after. Instead, staff routinely ask all parents, carers and young people if there is a social worker allocated to their care. The A&E team use the trust’s Report of Concern form to update social workers and the LAC team of any attendance at the department by a child or young person that they are working with. If staff are concerned about a child or young person, they telephone the children and families duty team to see if they have a child protection plan in place and where necessary make a referral. When any child leaves the department, the practitioner has to complete a proforma confirming that consideration of safeguarding was part of the triage. All attendances are also reviewed by the safeguarding lead for A&E who has recently introduced an audit on compliance with departmental guidance for safeguarding children. Routine notifications of attendance are sent out to GP and health visitors for children of all ages. It was reported that it was at the discretion of the health visitor whether the notification is forwarded to the relevant school nurse. This would mean that the school nurse may not have a complete health overview of a child or young person they may be working with. The risk of this, however, is mitigated by the trust’s policy where there is a requirement for the report generated by the health visitor to be copied to the school nurse by the community administration assistant. Any attendance that has generated completion of a Report of Concern Form is automatically coped to either the health visitor or school nurse.
4.3 The support provided to young people accessing the A&E department following self harm or requiring mental health assessment is adequate. The A&E staff use a single point of access for all referrals. Any young person under 16 who attends A&E out of hours following an incident of self harm will be admitted to the paediatric ward at Poole Hospital overnight until they are assessed by CAMHS the following day.

4.4 Ante-natal and post natal care is provided by the Royal Bournemouth and Christchurch Hospitals NHS Trust. Women have a choice on where to deliver their baby, with Poole Hospitals NHS Foundation Trust providing the consultant led service as well as a midwifery led unit and a stand alone midwifery unit provided by the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

4.5 The arrangements in place to identify safeguarding concerns during pregnancy and protect the unborn child are adequate. Booking clinics are scheduled in GP surgeries and routine ante natal clinics are offered in children's centres across Bournemouth. A full social risk assessment is carried out at booking and where there are concerns around vulnerabilities the woman is referred to the Sunshine Team. The Sunshine Team is a team of midwives employed by the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust that offer midwifery services to women who require an enhanced service. The partnership has drafted a multi agency care pathway for teenagers who conceive and wish to continue with their pregnancy. It is anticipated that the pathway will be introduced as from April 2011, however it still requires sign off by all partners. If there are concerns around the safety of the unborn child, then the midwife looking after the mother will refer the case to the children and families service for initial assessment. Referrals to the children and families services are copied to the Sunshine Team who will monitor their progress. There are no systems in place to quality assure the content of the referrals to children and families service or the content of reports prepared for child protection meetings.

4.6 The family health service delivers the healthy child programme through the use of skill mix consisting of health visitors, community nursery nurses, and school nurses. An assessment tool is used as part of each contact visit to help identify any vulnerability within a family. Caseload numbers within health visiting are variable and there has been some work around matching resource to deprivation and this resulted in re-organisation of staffing and the recruitment of additional posts. This work has allowed health visiting teams to deliver the healthy child programme, in full, up to the age of 5 years.

4.7 Health visitors are fully engaged in supporting families where there are children who have a child protection plan in place or where there is a child in need. The community nursery nurses carry out interventions identified in child protection or child in need plans under the supervision of the health visitor. Interventions include help with issues around sleeping, eating and behaviour management. The involvement of school nurses in safeguarding is starting to develop and strengthen. The school nurses at Band 6 are now starting to attend child protection meetings and write reports for conference.
4.8 Each of the high schools across Bournemouth has a named school nurse. The school nursing service is delivered through skill mix consisting of team leader, specialist practitioners, school health staff nurses and nursery nurses. There are good arrangements to support children into education through handover meetings between health visitors and school nurses and new parents meetings. The school nurses prepare care plans for any new child into reception where there are identified health needs. School nursing staff carry out the routine weighing and measuring and hearing checks as well as carrying out immunisation and vaccination of school aged children. Each high school has a drop in clinic run by the school nurse where they can obtain help and advice.

4.9 There is good access to sex and relationship education (SRE) in Bournemouth. There is a specialist team who deliver education into all schools, colleges and the university. Some members of the team are trained in delivering SRE to young people with disabilities. Individual programmes are tailored to meet the needs of this group of young people in close partnership with the education staff and school nurse. Feedback on this work has been very positive.

4.10 There is a good contraceptive advice and integrated sexual health service in Bournemouth. The services are delivered in integrated sexual health clinics where screening for asymptomatic sexually transmitted infections is available. There is good provision for young people at young person’s advisory clinics and contraceptive health clinics across Bournemouth. Young people can access services six days a week, though emergency contraception is available seven days a week. The service is branded ‘f-risky’ and is supported by a highly interactive and informative website that is well used. Young people have access to a dedicated telephone number which they can call or text for help and advice which is very popular. There are dedicated services available for young men that provide contraception advice as well as advice about sexual health and relationship problems.

4.11 There is good outreach support for young women who require assistance in accessing contraceptive advice and sexual health services. The outreach worker works with vulnerable young women in the community to help them access universal provision. She also follows up any young person who has received emergency contraception from local pharmacists well as providing support post termination of pregnancy.

4.12 The provision of advice, support and treatment on substance misuse to young people is good. The service is currently provided by YADAS (Young adults drug and alcohol service). YADAS is a multi agency, multi professional service that provides advice and support to practitioners in universal services as well as advice, support and treatment to young people. The service is accessed through multi agency or self referral and operates on an assertive outreach based approach seeing young people in a variety of settings. At point of referral the client is asked where they prefer to be seen and the practitioner will try and accommodate their request. This approach has led to improved attendance for treatment. The substance misuse liaison nurse is seconded to work with the A&E department at Bournemouth hospital. The liaison nurse will visit the hospital on a regular basis to speak to any young person who has been admitted to a ward through substance misuse and try to facilitate a referral for intervention. Outcomes are measured using the national treatment outcome tool for all clients. Over 70% of clients complete their treatment and feedback is generally positive.
4.13 Access to emotional support for children and young people in Bournemouth is improving. CAMHS support at Tier 2 is through the primary healthcare workers who work out of a number of different settings according to the need of the client. The tier 3 service is primarily clinic based though home visits are made where there is a clinical need. In response to unplanned staffing vacancies in tier 3 CAMHS, the service is operating with a risk assessed waiting list. The trust are actively addressing this waiting list and plan to have no young people waiting for treatment, once they have been assessed, by the end of March 2011. There is a good range of approved therapies for young people to access. There are now clear protocols in place to support the care pathways between different CAMHS services and a consultant psychiatrist holds a regular consultation clinic to support tier 2 practitioners which is well regarded. Services are offered to children and young people up to their 18th year and there are established mechanisms in place to facilitate the transfer of young people into adult services where appropriate and available. Tier 4 services are in a period of significant change; moving from traditional in patient provision to a crisis home treatment intervention service.

4.14 There is a well established and effective multi disciplinary learning disability service that works with children and young people age 5 to 18. There is good partnership working between the CAMHS and learning disabilities service with staff often co working cases. There are regular monthly meetings between the learning disability service and the children and families learning disability team. Members of the learning disability team work well with the special schools and often run workshops with the children and young people that have been evaluated as informative and fun.

4.15 The support offered to families with complex health care needs by health practitioners is adequate. The consultant community paediatrician will act as the co-ordinator for this cohort of children and young people. Initial assessments are carried out by multi agency, multi professional staff. There is a nursery group that young children attend where there are concerns around communication difficulties; this group is run by specialist therapy staff and is used to identify future need. Consultant Community Paediatricians are flexible around the age a young person will transition into adult services and will continue to provide advice and support until a young person is 18.

4.16 Children and young people who come into care have their health needs comprehensively assessed and reviewed. The initial health assessments are carried out by both the health visitor or school nurse and the GP. Once the assessment is complete it is then returned to the LAC health team where it is reviewed by the Medical Advisor for Adoption and Fostering who quality assures the content and creates the care plan. The health plans seen were comprehensive and of good quality. There are some delays in the timeliness of the initial health assessments taking place. The LAC health team has done some work in identifying the reasons for the delay and are working across agencies to address these.
4.17 The first annual health review takes place four months after a child or young person becomes looked after. All reviews are completed by a member of the LAC nursing team and any amendments or additions to the care plan are made. Latest statistics show outstanding progress is being made in ensuring that the children and young people are registered with a dentist (100%) and are up to date with their immunisations and vaccinations (100%). When a child reaches the age of 11, part of the health review involves a screening process to identify potential risks around substance misuse. If the screening identifies a concern or if the young person is misusing substances, then a referral can be made to YADAS for ongoing support and treatment. Young people confirmed that they were routinely asked to state their choice of where the health review took place.

4.18 The arrangements for monitoring and reviewing the healthcare of children and young people are less well developed. Where there are reciprocal arrangements in place with commissioning PCTs, then the relevant LAC health team will carry out the review. For those children placed in areas where there is no reciprocal arrangement, then either the designated nurses will travel to carry out the review or will issue a questionnaire to the carer, the health visitor or school nurse and the child or young person, if appropriate. They will then use the responses to formulate a care plan which is then monitored the usual way. The clinical psychologist is involved in the negotiation and review of placements where CAMHS is part of the service being commissioned.

4.19 The LAC health team use the Strengths and Difficulties Questionnaire (SDQ) to routinely monitor the emotional health and wellbeing of the children and young people. SDQs are completed when a young person becomes looked after, with the carer, teacher and child completing the assessment form. The completed forms are scored and then the results are fed back to the LAC health team who use the findings to inform the initial health assessment and annual health reviews.

4.20 There are good arrangements in place for looked after children and young people to access services to care and support their emotional health and wellbeing. There is a dedicated LAC psychology service with a referral processes in place should further intervention be required from core CAMHS.

4.21 The provision of SRE to young people who are looked after is good. Young people who are looked after access universal services for advice around sex and relationships. Foster carers and staff working in the children's homes receive training in SRE and are encouraged to discuss this with the young people that they care for. SRE is also discussed at each annual review and there are good links with CASH, including outreach services. The LAC health team are trained in C-Card and Chlamydia testing. The team monitor the number of pregnancies within the LAC population and identified an increase in numbers that puts them slightly above the national average. If a young woman conceives and wishes to continue with the pregnancy she is referred to the "Sunshine Team" who will provide her midwifery care.

4.22 The arrangements to prepare and support young people with their healthcare on leaving care are adequate. The LAC health team will support care leavers up until their 21st birthday, however, young people leaving care are not provided with a comprehensive health record.
5.1 There is good support offered to foster carers through the input of the LAC health team and the clinical psychologists into a comprehensive training programme that includes input from the CASH outreach worker. The clinical psychologists run a one year course on developing secure attachments that is also attended by social workers for fostering. The clinical psychologists described how attendance on the course had led to increased stability in the placement for children and young people.

5.2 The arrangements in place to identify and support young people with complex medical needs through the transition into adult services are good. There is a continuing healthcare case manager who works with families and across agencies to identify and co-ordinate the health plans of children from aged 14 until they leave children’s services at 18.

5.3 There are good transition arrangements in place between the young people’s substance misuse service and adult services. The new contract states that there should be flexibility around the age of a young person transferring into adult services. The age of the transition can be anywhere between a young person reaching 18 up to 25 years to recognise individual needs and vulnerabilities.

5.4 There is good partnership working between CAMHS and YADAS. If YADAS see a young person and feel that a referral to CAMHS is necessary they are able to book straight into a clinic appointment and therefore reduce any delay.

5.5 All health practitioners interviewed were confident in how to refer concerns to children and families services. Most confirmed that thresholds were relatively well understood and applied equitably. When a staff member received an invitation to attend a child protection or child in need meeting, they felt well supported by their organisation in preparing a report for conference and in attending the conference where appropriate.

5.6 When a referral had been made to children and families and there is a professional disagreement about the response, there is no jointly agreed escalation process between health partners and the local authority, with different teams adopting different processes. The Bournemouth and Poole CHS have a formal notification system in place that is regularly audited by the named nurse to identify any trends or training needs however this is not shared or agreed with partners.

5.7 There is good partnership working across all agencies to identify and protect children and young people from the impact of domestic violence in families. Risk assessments in midwifery and health visiting include screening for the incidence of domestic violence with clear referral pathway to MARAC where high risk is identified. Health visitors receive the notifications from police when they have attended an incident of domestic violence where children were present. There are good arrangements in place to identify and refer to children and families service any attendance at A&E by an adult and there are concerns around substance misuse, mental health concerns or domestic violence.
6  **Outcome 7 Safeguarding**

6.1 The South West Strategic Health Authority have strong oversight on safeguarding children and seek regular assurance from the Bournemouth & Poole PCT that national and local priorities are implemented and reported on.

6.2 There is good multi agency health representation on safeguarding across Bournemouth, Poole and Dorset through the Safeguarding Children and Young People Group in Health which meets quarterly and is well attended by named and designated safeguarding children professionals. This forum allows sharing of good practice and acts as a collective voice for health in responding to regional and national findings and initiatives.

6.3 The designated nurse for Bournemouth & Poole Teaching PCT is employed full time in the post. She is line managed by the Director of Public Health who is also the PCT lead for safeguarding children. Bournemouth & Poole PCT are working with providers to establish the arrangements for the designated doctor for LAC.

6.4 There is good support offered to general practitioners in helping them to fulfil their responsibilities in safeguarding children. Bournemouth & Poole PCT have provided training sessions on safeguarding children with the most recent event covering key learning from serious case reviews. There are plans in place to hold further training events covering Level 3 content. However, the PCT do not currently hold statistics around the number of GP and other independent practitioners that have attended safeguarding children training. Each GP practice has a named GP as safeguarding lead. In response to a recent serious case review, primary care are working in partnership with A&E to improve communication around attendance of children to urgent care. Plans to standardise recording of child protection in primary care are well advanced with a proposal document now ready for consultation across the partnership.

6.5 There are appropriate arrangements in place for the named nurse and named doctor in the Bournemouth & Poole Community Health Services. The named nurse is supported by three safeguarding nurse advisors and a domestic violence co-ordinator (3WTE). The team have 1WTE dedicated administrative support.

6.6 The LAC health team consists of 1.4WTE designated LAC across two posts and 1WTE LAC team nurse. There is no designated doctor for LAC in post, though this is now being addressed by the PCT with a provider trust. The majority of the duties for this post were reported as being covered by the LAC team manager and the Medical Advisor for Adoption and Fostering. Concern was expressed about the lack of resource for these additional duties by the Medical Advisor. There is 0.8WTE dedicated psychology input into the LAC team across three posts.

6.7 The arrangements to support the named nurse for the DHUFT are adequate. She is employed on a full time basis and reports to the Patient Safety Lead for the trust who heads the patient quality and safety directorate. She has direct access to the trust's executive lead for safeguarding children and meets bi monthly on a formal basis. The named nurse receives her supervision from the PCT designated nurse. The arrangements for the named doctor for the trust were less clear, however, it was confirmed during the course of the inspection that the named doctor has been allocated dedicated time for the role and that a job description, work plan and supervision arrangements will be formalised as a priority action.
6.8 There is a safeguarding section on the DHUFT intranet site that is maintained by the named nurse that gives staff access to local and national reports, local safeguarding policies as well as local contact details for safeguarding children. The named nurse has recently developed a set of CAMHS safeguarding standards. These standards are used as part of the induction process for new staff and there is an intention to monitor compliance against the standards.

6.9 The DHUFT have arrangements in place to ensure that children and young people who are in contact with service users of adult mental health services are identified and safeguarded. The trust has recently carried out an audit into practitioner compliance with the trust policy and produced an action plan to address the findings.

6.10 The arrangements for the named safeguarding professionals in the Royal Bournemouth & Christchurch Hospitals NHS Trust are inadequate. The role of named midwife is incorporated into the role of head of midwifery. The head of midwifery is the trust's named midwife and named nurse for children safeguarding. She does not have a formal job description. Support to the named roles is through one senior midwife who has 7 hours allocated for safeguarding support in midwifery and a nurse in A&E who has been allocated 7.5 hours to support safeguarding in A&E. The named doctor does not have a formal job description for the role or any allocated sessional time. The named doctor does not receive any formal appraisal in his role and does not have access to safeguarding supervision. The named doctor has not completed Level 4 safeguarding training. The trust have recently submitted their Section 11 return to the Bournemouth & Poole PCT and South West Strategic Health Authority and it is evident that the lack of resource is impacting on the trust’s overall compliance with good safeguarding children practice.

6.11 Bournemouth health partners are part of the pan Dorset Child Death Overview Panel (CDOP). The panel is effective. It is appropriately established and funded and is using findings to influence policy and guidance. The panel has recently raised the issue of alcohol by parents, especially in early years. This issue is being taken up across the county as part of the hidden harm agenda. The review of individual deaths has also influenced local changes to practice. An example was given how staff at the Poole Hospital have now been trained to ensure that end of life care is culturally sensitive. The hospital has also commissioned bereavement training for some staff so that they can act as a resource to families and also colleagues.

6.12 The arrangements for children and young people to receive a forensic examination following an allegation of sexual abuse are adequate. Currently, the examination takes place at the Bournemouth Police Rape Forensic Suite by a consultant paediatrician and a forensic physician. All staff carrying out examinations are appropriately trained. The suite has specialist equipment for children and young people. A new SARCs centre has been commissioned and is expected to open during spring 2011. The arrangements for child protection medicals are adequate and usually take place in the children’s unit at Poole General Hospital.
7. **Outcome 13 Staffing numbers**

7.1 The numbers of staff working in the A&E department at the Royal Bournemouth Hospital who have a paediatric qualification does not allow for a paediatric nurse to be rostered for each shift on the A&E department. To mitigate this, the trust has made good effort in sourcing specific training in caring for the sick child in urgent care and for advanced paediatric life support skills. They also have agreed protocols and pathways in place to seek support from paediatricians employed by the neighbouring trust, Poole Hospitals NHS Foundation Trust. The Poole Hospitals NHS Foundation Trust also has a 24 hour, 7 day week rota for safeguarding children which covers the Bournemouth area.

8. **Outcome 14 Staffing support**

8.1 The arrangements for training and supervision in safeguarding children within the Bournemouth & Poole Community Health Services are outstanding. The named nurse has carried out a detailed training needs analysis to identify the appropriate level of safeguarding children training for all posts within the community health services. Good progress is being made and it is expected that by the end of March 2011 approximately 95% of all staff will have received appropriate training across all levels of safeguarding children.

8.2 The safeguarding team for Bournemouth & Poole Community Health Services provide quarterly supervision for all staff who have caseloads that include children where there is a protection plan in place or where there is a child in need identified. The supervision is rigorous and is also used as an audit tool to monitor compliance with safeguarding policies and guidance.

8.3 Training in safeguarding children within the DHUFT is good. Training at level 1 and level 2 incorporate both safeguarding children and safeguarding vulnerable adults. There have been some problems in accessing multi agency safeguarding children level 3 training, however, the trust has a detailed plan in place to address any shortfall and is making good progress. Arrangements for the supervision of DHUFT who are holding cases where there are child protection or child in need issues is inadequate. Safeguarding is a standing agenda item on all team meetings and cases are discussed as part of group supervision and the named nurse is available to give advice on request. The supervision is automatically recorded on the trust's IT system on the patient record. The named nurse is unable to easily identify or monitor when individual practitioners have accessed supervision.

8.4 Training of staff in safeguarding children within the RB & CH NHS Trust across is inadequate. The named nurse has recently carried out a detailed training needs analysis and has a plan in place to ensure that all staff will receive the training appropriate to their role. It is too early in the process to determine progress. There is, however, evidence of high numbers of staff trained in safeguarding within the A&E department.

8.5 The RB & CH NHS Trust do not have robust arrangements in place to ensure that practitioners working on child protection and child in need cases receive timely safeguarding supervision.
9 **Outcome 16 Audit and monitoring**

9.1 Bournemouth & Poole PCT have good arrangements in place to monitor provider compliance with the requirement to safeguard children. The PCT use a balanced scorecard with a number of metrics that are regularly reviewed to reflect local priorities. The PCT has a Clinical Governance Committee that is a formal sub committee of the board and is chaired by a non executive. The designated nurse prepares a formal report to the Quality Committee of Commissioning that incorporates an overview of actions on serious case reviews and any other serious incidents. In addition, each of the provider organisations are required to submit quarterly safeguarding children reports to the PCT’s monthly contract monitoring meetings.

9.2 An example of effective action taken following a recent audit by the Bournemouth & Poole PCT identified poor attendance by general practitioners at child protection meetings and some child protection meetings were taking place without a report from the GP. The designated nurse has carried out work with GP practices and there are early signs of improvement. Each practice is visited annually by the primary care commissioning team to discuss performance.

9.3 The Bournemouth & Poole CHS have appropriate governance arrangements around safeguarding children. The Deputy Chief Operating Officer for the service is a member of the Bournemouth LSCB. The service has a safeguarding group that is chaired by the Deputy Operating Officer and lead for children's services. The safeguarding group report to the Clinical Governance Group monthly through performance reports on key performance indicators and the quarterly safeguarding report that is also shared with the commissioners at the monthly contracting meetings.

9.4 The Bournemouth & Poole CHS are commissioned to provide the full healthy child programme and there is close scrutiny of key contacts. The service are currently meeting or exceeding their contract targets. The service has recently developed an outcome measure to look at the impact of the health visitors on the emotional health and wellbeing of new mothers. Early findings are very positive with approximately 85% of new mothers reporting that the advice from the health visitor made a difference.

9.5 There are good arrangements in place to quality assure reports produced for case conferences by community health service staff. The safeguarding nurse advisers and the named nurse operate a duty rota to check all reports prior to them being sent to children and families. All referrals to children and families are reviewed during supervision.

9.6 The Bournemouth and Poole CHS have a policy is place to ensure that there is a risk based approach to address instances of where a child misses an appointment.
9.7 The DHUFT have good reporting arrangements in place to provide board assurance on safeguarding. The Director of Children and Young People’s Service is the named executive lead for safeguarding children within the trust. She attends the Bournemouth LSCB. The Director of Children and Young People’s Services chairs the trust's integrated children and adult safeguarding group, alternating with the medical director. All directorates within the trust exception report on attendance at safeguarding children training. The trust board receive quarterly reports from the integrated child and adult safeguarding group as well as the formal public annual report.

9.8 The named nurse for DHUFT does not routinely receive copies of referrals to children or families; neither is she copied into reports for child protection conference. There are no regular audits on the referrals made or on the quality or timeliness of reports for conference. The named nurse does, however, become involved where practitioners have made a referral and this has escalated because of professional disagreement. The named nurse acknowledges that there is a need to develop a joint escalation pathway between health and children and families service.

9.9 The DHUFT have carried out audits into some areas of safeguarding practice, however, this has been limited to evaluating safeguarding awareness and implementation of actions following serious case reviews. There is an annual record keeping audit that the named nurse is looking to include some questions around safeguarding practice.

9.10 There is evidence of learning from serious case reviews in DHUFT. The trust demonstrated early progress in improving communication between CAMHS and education; albeit this was further advanced in Poole than Bournemouth. The trust has recently audited how practitioners identify and risk assess children who have contact with or are cared for by adult patients. The audit had shown good compliance with recording details of children and recording of the impact of adult mental health on children. Recommendations from the audit included the need to transfer the outcomes from the risk assessment on the impact of adult mental health issues on any children into the care plan, as well as ensuring the Consultant Psychiatrist was routinely consulted as part of the escalation process when there are concerns.

9.11 The DHUFT is in the process of implementing a new policy to ensure that if children, young people, or adults who have responsibilities for children who are on a child protection plan do not attend a health appointment, their details are made available to the named nurse for follow up.

9.12 There is a good structure in place to support board assurance and governance for safeguarding children within the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust. There is a children safeguarding sub group that is chaired by the named nurse. The sub group is part of the trust safeguarding committee which reports to the Healthcare Assurance Sub Committee which is a formal committee of the trust board and is chaired by a non executive director. The trust, however, has not adequately resourced the named professionals within the trust and this is reflected in their Section 11 return and lack of compliance with Working Together 2010.
9.13 The RB & CH NHS Trust do not have a trust wide policy on non attendance of children at out patient clinics. There is a DNA Policy within midwifery services and the named nurse is in the process of adapting this and rolling it out across the organisation.

9.14 The named nurse for RB & CH NHS Trust does not routinely audit or quality assure the referrals to children and families service or the reports prepared for child protection conferences. There is, however, regular audit carried out in the A&E department to look at safeguarding referral patterns and information used in the referral. There is no history of rigorous audit on compliance with safeguarding children policy and guidance.

10 Outcome 21 Records

10.1 The health records of children with a child protection plan or child in need plan inspected show good multi agency working. Health staff regularly attended meetings and prepared reports for conference. Records contained notifications from A&E and the police around any child's attendance at A&E or where there had been an incident of domestic violence. The records had good chronologies and in the main complied with the NMC standards for record keeping. Files contained evidence of the health practitioner receiving effective safeguarding supervision.

10.2 The health records for looked after children contained initial health assessments, health reviews and care plans that were mostly of good quality and all were appropriately completed and monitored.

11 Recommendations

Within 3 months (from report)

Ensure that the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust takes action to:

- clearly identify named health professionals and allocate sufficient time for their roles
- ensure that routine notifications following the attendance of any child or young person at the accident and emergency department are shared appropriately with the relevant health visitor or school nurse.
- ensure that the appropriate consent is obtained for young people attending the accident and emergency department following an incident of substance misuse. (Ofsted, March 2011)
Ensure that the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust take action to:

- ensure that practitioners have appropriate supervision in safeguarding children.
- ensure that referrals made by health staff to children’s social care services are appropriate and of high quality, and that reports to child protection conferences are of high quality.
- ensure that a multi-agency protocol is in place for escalating concerns when there are disagreements about whether thresholds for referral to children’s social care services are met (Ofsted, March 2011).

Ensure that looked after children and young people who are placed out of the area receive high quality provision of health services. (Ofsted, March 2011)

Ensure that when young people leave care they are provided with a comprehensive health record. (Ofsted, March 2011)

Within 6 months

Ensure that the health needs of looked after children and care leavers are clearly identified within the Joint Strategic Needs Assessment. (Ofsted, March 2011)

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.

To: Ann Swan, Chief Executive, NHS Bournemouth & Poole

Cc: Mr I Biggs, CQC Regional Director
    Ian Carruthers, Chief Executive, South West Strategic Health Authority
    Ms Mandy Cox, Safeguarding Lead, South West Strategic Health Authority