

Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Bath & North East Somerset

Date of Inspection	9th January 2012 – 20th January 2012
Date of final Report	24th February 2012
Commissioning PCT	NHS Bath & North East Somerset (South Gloucestershire lead commissioner for adult mental health)
CQC Inspector name	Ms Jan Clark
Provider Services Included:	Oxford Health NHS Foundation Trust Sirona Health and Social Care The Royal United NHS Hospital Trust, Bath Great Western Hospital Foundation Trust Avon & Wiltshire Mental Health Partnership NHS Trust Bath NHS Healthcare Centre (walk-in centre) Beaumonts (Quarriers) for residential short breaks for disabled children.
CQC Region	South West
CQC Regional Director	Mr Ian Biggs

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](#) .

Bath & North East Somerset Council	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
The contribution of health agencies to keeping children and young people safe	Inadequate
Looked After children Inspection Outcome	Aggregated inspection finding
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Being Healthy	Inadequate

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:

Bath and North East Somerset (BANES) has a resident population of approximately 33,283 children and young people aged 0 to 18, representing 18.8% of the total population of the area. In 2011, 9.1% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall. 3.5% of the school population are of a mixed/dual heritage background. 3.2% of pupils speak English as an additional language. The proportions are very low for each of the wide range of languages spoken. Polish is the most recorded commonly spoken community language of pupils but forms less than half a percent of the total.

The BANES Children's Trust Board was established in January 2008. The board agreed that it would continue as a non-statutory board in September 2010, at which time it also reviewed its governance and membership. The Trust currently includes representatives of the local authority, independent chair of the local safeguarding children board (LSCB), primary, secondary and college representation, health, police, the voluntary sector and the transitions board. It also includes the chairs of the delivery and strategy groups who lead on the delivery of the Children and Young Peoples Plan. The BANES safeguarding children board was established in 2006 and has been independently chaired since June 2010. With three other LSCBs, it has established the West of England child death review panel (CDOP).

Community-based children's social care services are provided by teams covering North East Somerset and the city of Bath. The latter is currently piloting new approaches to the delivery of services following a lean review of social care processes. These provide contact referral and assessment services and social work services to children in need, subject to protection plans or entering care. The family placement team provides the council's adoption, fostering and family link services. The emergency duty and out of hours service is provided through a consortium with North Somerset, South Gloucestershire and Bristol.

At the time of the inspection there were 161 looked after children. They comprise 29 children less than five years of age, 110 children aged five to 16, 22 young people aged over 16 and a total of 64 with care leaver status. At the time of the inspection there were 84 children who were the subject of a child protection plan. These comprised 35 females and 45 males of which 2 were unborn children. About 37% of these children were aged under 5, 36% were aged 5 to 11 and 25% were 12 years or older. The highest category of registration was emotional abuse at 51% followed by neglect at 39%, with physical abuse at 5% and sexual abuse also at 5%.

NHS Bath & North East Somerset and Bath and North East Somerset Council have formed a Partnership for Health & Well-Being to undertake the integrated commissioning of health & social care services for adults and health services for children. Commissioning for children's health services sits within the Council's children's services management structure with some joint funding of posts.

Commissioning of Primary Care services is undertaken by NHS Bath and North East Somerset. Child and adolescent mental health services (CAMHS) commissioning is aligned through a joint contract between the PCT, Council and NHS Wiltshire (who are the lead commissioner). CAMHS services are provided by Oxford Health NHS Foundation Trust.

Universal services such as health visiting, school nursing, community paediatrics, and speech and language therapy are delivered by the recently established Community Interest Company, Sirona Health and Social Care. The acute hospital providing accident and emergency services, neo-natal and paediatric services for children is the Royal United NHS Hospital Trust, Bath. Maternity and newborn services are provided by Great Western Hospital Foundation Trust at the Princess Anne Wing at the Royal United Hospital. Adult mental health services are provided by Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). This provision is jointly commissioned with other local PCTs and NHS South Gloucestershire is the lead commissioner.

Children and families access primary care services through one of 27 GP practices, and walk-in centres including, Bath NHS Healthcare Centre, and the Urgent Treatment Centre and minor injury centres at Paulton Memorial Hospital. For children with learning difficulties and who have complex health needs, services are provided by the Lifetime Service which is part of Sirona Health & Social Care. The PCT and Council jointly fund short break services through Beaumonts (Quarriers).

General – leadership and management

- 1 The strength of leadership and management within the multi-agency partnership in which health agencies are actively engaged, have been judged as adequate and there is close partnership working with joint commissioning arrangements. There has however, been insufficient leadership, performance management and drive for improvement by the PCT NHS Bath and North East Somerset in relation to safeguarding over recent years. As a result, health's contribution to safeguarding arrangements has been judged by the inspection as inadequate due to a failure to meet statutory guidance in key areas. No designated nurse role as set out within statutory guidance *Working Together* has been in place within BANES PCT for three years. The impact of the absence of this role is significant in ensuring, on behalf of the PCT and LSCB, that the safeguarding practice of children's healthcare providers is of a satisfactory standard, and subject to strong governance and accountability across the whole health economy. Current safeguarding governance arrangements of health providers as operated by the joint commissioners are not robust and provide insufficient challenge to levels of health service delivery. Given the improvement agenda and span of responsibility of the designated nurse across two PCT areas, the post's capacity for delivery is of concern.
- 2 Similarly, the provision of healthcare to looked after children is also inadequate. There is no designated doctor or designated nurse role, required under statutory guidance, set out within the jointly commissioned contract with the service provider and these roles are not assigned within the provider service. The absence of these designated roles has significant impact on strategic oversight, performance management and quality assurance resulting in deficits in key areas of delivery and placing at risk the delivery of good health outcomes for young people in care. There is no identified strategic lead in the provider developing and driving an improvement agenda, ensuring provider performance effectively and unblocking any operational difficulties across the partnership interface. Health is not a member of the corporate parenting board and therefore a potential lack of health perspective exists at this level. Lines of accountability to the LSCB or other governance board are not clear.
- 3 The council and its partners have ambition and appropriate priorities that are reflected in the Children and Young People's Plan (CYPP) and in the LSCB business plan and the joint inspection found adequate capacity for improvement overall within the partnership. The NHS BANES and Wiltshire PCT Cluster has prioritised children's safeguarding, allocating clear directorate responsibility through the director of nursing and patient protection. A designated nurse for children's safeguarding has been appointed to NHS Wiltshire and is currently acting across BANES, undertaking a review of safeguarding provision and implementing and improvement plan. At the time of the inspection, the designated nurse had been in post for eight weeks and it was too early to identify sufficient or sustained improvement. Sirona, the looked after children health service provider, had planned a board paper for Sept 2011 setting out areas for development re: health provision and capacity for looked after children. This was deferred due to the transition of services and other business seen as priority. Areas for development identified by lead managers in the provider are largely reflected in the findings of the inspection and improvement actions have been taken promptly.

Outcome 1 Involving Users

- 4 Sirona Health and Social Care, the health provider service for looked after children, is flexible in where services are delivered and young people and carers have a good level of choice in where they can access immunisation services. The health looked after children team work hard and to good effect to ensure that children in care are engaged with the health assessment process. In the last year, no young people aged 11-16 have refused health assessments and there have been only four refusals out of 42 for young people aged 16+. Over the past year, a speech and language therapist has played a lead role in joint work with social care to better involve children with limited or no verbal communication in their reviews.
- 5 Other than in recruitment of key health personnel in Sirona, young people are not well engaged with the strategic development and delivery of the Being Healthy agenda for looked after children. The In Care Council is an active and influential group of young people who are experts by experience of the care system. They have recently been at the centre of the refresh to The Pledge which includes health specific undertakings. They had also been instrumental to the production of two packs of PSHE DVDs; one for primary schools and one for secondary schools.
The young people had written, directed and selected the film company to produce the films in which actors portrayed scenes drawn from young people's real experiences. These are powerful DVDs with the scope to be highly influential with both professionals and other young people. With the lack of the designated nurse role, health have no strategic engagement with the In Care Council and no process is in place by which the In Care Council can hold health partner agencies to account for delivery of the health elements of The Pledge.
- 6 Support to care leavers is under developed. Information on health and wellbeing given to care leavers was developed with young people's participation but has not been reviewed recently jointly with the In Care Council. Following the last health review, there is effective liaison by the lead consultant with the young person's GP who is also sent the report. Whereas the report is also offered to the care leaver, young people told inspectors they did not find the documentation format particularly accessible or useful to them. As there is no current health engagement with the In Care Council, there has been no opportunity for young people to explore this with the provider and for the co-production of user friendly care leaver information.
- 7 There is very positive mental health service user engagement being developed by Oxford Health NHS Foundation Trust. Young people and carers engaged with the CAMHS service are very involved through a strong service user network in service development and outcome evaluation. The outreach service for children and adolescents (OSCA) supports a well attended young people's discussion group. Young people had visited the in-patient unit in Swindon to meet younger children and help them express their experiences in order to help develop services in a child friendly way and are actively supporting younger patients to participate. Three short films on young people and mental health have also been co-produced for use at the Olympics.

- 8 Sexual Health For Everyone (SAFE) sexual health services have been mystery shopped against “You’re Welcome criteria” by young inspectors. Young people developed the resultant recommendations across a range of venues and services to develop young person friendly aspects of service. Recommendation areas included; confidentiality, information, staff knowledge and professionalism, Chlamydia screening and feedback. Evaluation of the findings, outcomes and lessons learnt are informing the development of a rigorous process to grant and revalidate SAFE status. The continued engagement of young people in this process is a core principle.

Outcome 2 Consent

- 9 Consent to undertake health assessments is obtained by the looked after children health team in accordance with the Department of Health’s Guidance.
- 10 Within health providers there are appropriate policies and procedures in place that ensure consent is taken prior to any treatment of children and young people. Consent is gained from parents and carers and is appropriately documented.

Outcome 4 Care and welfare of people who use services

- 11 Social care do not routinely share the list of looked after children with the looked after children health team and the notification system whereby social care inform the looked after health team of young people coming into and leaving the care system and changes of placement is not robust. Delays in notifications being sent to health and the use of incorrect documentation by social workers is impacting on performance for the completion of initial health assessments within required timescales which has diminished from 89.5% to 70.8% over the past two years. All initial health assessments are undertaken by or under the direction of the lead consultant paediatrician and the quality of initial health assessments is satisfactory.
- 12 However, health plans set out at the end of assessments are not SMART, and it is not always clear what actions are being taken to address the health needs which have been identified eg a fear of dentists being identified in the health assessment but nothing in the health plan setting out what actions are being taken to address this need with the young person and assure the child’s dental health. Management and monitoring of information sharing between social care and health is not robust. As a result, children at risk of missing out on health provision may not be identified at the annual looked after children review.

- 13 Detailed delivery plans, constituting the way the foster carer's or placement provider's should address the child's health needs identified in their assessment, are developed from the overarching health plan but these are held by the child's foster carers without a copy on the child's health record. No effective process is in place to ensure the detailed delivery plans are routinely transferred with the child when changes of placement take place. Without routine managerial oversight of the health delivery plan, progress on longer term health challenges for some children is difficult to ascertain. Where changes of placement take place and health are not notified promptly, reviews of health needs do not routinely take place and there is no effective mechanism by which Sirona is assured that detail actions agreed in the previous placement have transferred to the new placement.
- 14 Appropriate foster carer training and health promotion work is in place with the looked after children's nurse well working closely with the range of sexual health services. Child and adolescent mental health services (CAMHS) operate an open and self referral system with specialist support which is effective in providing support to fragile placements. Looked after children are fast tracked to specialist health services when needs are identified.
- 15 CAMHS services including the discreet learning disability service and specialist eating disorder service, offer a good range of quality therapeutic and supportive interventions including Dialectic Behavioural Therapy (DBT) to children and young people including those without formal diagnosis. Services have been strengthened through recent reconfiguration and additional investment into tier 2 service development. The outreach service for children and adolescents (OSCA) provides effective year round crisis intervention available 24 hours per day. Fragile foster placements are being successfully sustained and admissions and lengths of in-patient stays have significantly reduced. When young people do require in-patient mental health treatment, beds are provided in a specialist unit in Swindon.
- 16 The specialist CAMHS eating disorder service delivers good outcomes and offers effective specialist support to young people with eating disorders who are placed outside the local council area. There are positive relationships and daily contact with the acute hospital's children's services where young people have no difficulty in accessing CAMHS support when needed. CAMHS are not currently engaged with MARAC arrangements, however. Whereas transitions for young people with learning disability work well, there is not yet an agreed protocol in place guiding transitions into adult mental health services. Opportunities for staff and managers to regularly meeting to develop operational relationships and ensure cohesive working across the CAMHS and adult mental health service interface have yet to be established.

- 17 There is positive engagement by schools in the Healthy Schools programme with clear examples of good health outcomes across a range of health issues resulting for children of all ages. Although lower than the national and regional average, childhood obesity is a priority issue locally with 8.4% and 16.7% of reception and year 6 children being obese. A 'Tackling Childhood Obesity' DVD has been commissioned and distributed across children's services to raise awareness of the issue. Childhood body mass index (BMI) has decreased by an average 1.5 BMI unit and waist circumference has decreased by an average 2.1cm. The Healthy Schools Plus programme has also been introduced successfully. School nurses support to parents is effective and highly valued by partner agencies.
- 18 Good quality sexual health services are well established and the SAFE brand is well known and well regarded by young people. Services are easily accessed by young people with centrally located venues such as the Walk in Centre and condom vending machines at local colleges. The teenage pregnancy rate is low and significantly better than the England average. The rate of under 18 terminations is also significantly lower than the England average, but the percentage of terminations carried out before 10 weeks gestation is significantly worse than the average. Good support for young mothers is provided by midwifery services and the Walk In Centre. This support is provided early through well established use of CAFs and ensures young parents have good access to a range of specialist services and advice. Chlamydia screening coverage in BANES is higher than the regional and national average, although all areas in the South West are missing the national target of 35% annual uptake. The percentage of people testing positive in BANES is lower than the national and regional average.
- 19 The Walk In Centre, operated by a local GP partnership and located in the city centre is easily accessed by the large student and significant tourist population (25% of attendees) and is well attended. As there is no patient registration and where no history of individuals is known, close attention is paid to risk assessment although the centre does not receive information on which local children are subject to child protection plans or who are looked after children. The centre is well supported by the named nurse in Sirona, who provides training and acts as an effective conduit for advice guidance and referrals; but the centre has not yet had the opportunity to engage with the new designated nurse arrangements. It is not engaged with the LSCB and is not aware of the work of the child death over view panel, reporting little sense of connection with overarching safeguarding arrangements.
- 20 The provider of substance misuse services for young people unexpectedly went into administration in November 2011 with 84 young people in active treatment. Commissioners and the very committed staff team, as well as the charity, Comic Relief, which agreed to continue funding, responded promptly to take remedial action and at the time of the inspection, 44 young people had been re-engaged in treatment with a target of 60 by the end of February. Outcomes from the service are positive and young people involved with the service, project 28, told inspectors the service is "life changing".

Outcome 6 Co-operating with others

- 21 Health providers are represented on the LSCB at appropriate levels to affect change within their organisations, although attendance at the quarterly meeting is variable. Operational partnerships with partner agencies are reported across health services as positive. While health staff attendance at child protection meetings is improving, further improvement is required. In 2010/11, health visitors attended 95% of the 108 possible conferences, and sent reports to 87%. School nurses attended and submitted reports to 76% of possible conferences and paediatricians attended 11% of possible conferences sending a report for 94% of these. Health services staff report that their opinions are not fully recognised within case conferences and some report not being fully informed of the specific child protection concerns under discussion which undermines their contribution to risk assessment, decision making and protection planning. Such issues have been resolved in individual cases with the support of the appropriate safeguarding lead, but remain a wider issue to be tackled.
- 22 General Practitioner engagement with safeguarding arrangements is improving but is not yet adequate. There is no named GP to provide direct work across practices and the lack of designated nurse role has resulted in insufficient drive across health and social care to evaluate consistency and the quality of general practitioner contribution to case conferences. The designated doctor provides good quality three year training for GPs and this is valued by those who attend. Pharmacists are not yet engaged in arrangements.
- 23 Recent multiagency meetings to review cases for the inspection, demonstrated that health was not well informed about looked after children placement changes and that reviews of health have been missed as a result. The absence of assigned designated roles operating strategically has meant that health have not taken a proactive approach to addressing this with social care to ensure information pathways are robust. Minutes of annual looked after children reviews and care plans are not shared with the looked after health team and health reviews are not sufficiently co-ordinated to fit well with the timing of the looked after children review. Adoption and fostering panel arrangements are working well with clinical support provided by the lead looked after children paediatrician acting as designated doctor.
- 24 Clear and effective systems are not in place to ensure that looked after children placed out of area receive health care that addresses their physical and emotional needs. The consultant paediatrician and looked after children's nurse do see children placed within practical distance which encompasses most looked after young people. However, as health professionals do not routinely attend looked after reviews, robust quality monitoring arrangements for the cohort of children not seen by BANES health practitioners due to geographical location are not in place. These children are likely to have high complexity of need and therefore vulnerability.

- 25 Where there is a CAMHS involvement with a child placed out of area, the service will continue direct engagement within a reasonable geographical distance. Where a young person needing mental health support is placed further afield, the CAMHS service engages proactively with local providers to ensure smooth transition on an individual clinical need basis. Consultative support is also offered where a child is in an out of area school placement. The looked after children health team may not be well informed about when a child placed out of area is receiving specialist support in this way, however. One case within the sample illustrated this; whereas the young person was receiving CAMHS support which was effective in addressing mental health needs, the looked after children health team were not aware of this child who had not had a comprehensive assessment of all their health needs and effectively sat outside of the looked after children health system.
- 26 Services for children with disabilities and life limiting illnesses are good quality working effectively in a multi-disciplinary and multi-agency way as a team around the child and family. Specialist health visitor support provides early intervention and there is an effective transition panel in place to oversee smooth transitions into adult disability services. The Lifetime service for children with life limiting illness is particularly valued by other professionals.

Outcome 7 Safeguarding

- 27 The newly formed BANES and Wiltshire PCT cluster identified the non compliance with statutory guidance *Working Together 2010* and has acted promptly to put the designated role in place. A knowledgeable and experienced professional took up post eight weeks ago as designated nurse for Wiltshire and is also undertaking the role for BANES currently. The designated nurse is beginning to establish the required relationship between commissioner and providers, while undertaking a review to assess effectiveness of delivery of safeguarding activity across the health community. Whereas the designated nurse is developing an improvement plan with some early deliverables; with responsibility for two adjoining local authorities involving a complex economy of health services, an assessment of the capacity of the role to deliver necessary improvement and which presents significant challenge, is an objective of the review.
- 28 Sharing of information in relation to children looked after or subject to child protection plans between social care and specific health services is not consistent. Lists of these children are sent weekly by social care services to named professionals in the acute hospital and to community health services and health providers, who find this helpful in identifying children at risk. However, this information is not shared routinely with the CAMHS service which has to identify looked after children and those children subject to plans on a case-by-case basis.

- 29 Named nurses and doctors in provider services are knowledgeable and accessible to staff across services but in the absence of a designated nurse role within the PCT, support and practice oversight arrangements for this cohort of lead professionals has been limited. Positive support is being given to frontline staff participating in formal child protection processes although where the named nurse role is not a dedicated one, but is part of wider operational responsibilities, capacity to take on all aspects of the role including delivery of training and development, supervision, and comprehensive performance monitoring and management, is limited.
- 30 Health providers recently reviewed their response to children who do not attend health appointments and have significantly strengthened how they promote attendance and ensure a prompt response by health professionals to non attendance. Clinicians proactively send out reminders using a range of modes of communication including texts. This has resulted in a significant reduction in non attendances. Further work is required to ensure that social care services engage in the non attendance protocol to trigger referrals and responses.
- 31 Governance of children's safeguarding practice at RUH NHS Trust is not sufficiently robust. While staff seen demonstrated an awareness of safeguarding risks, lessons learnt from significant incidents that sustain improved practice, are not embedded. Basic and advanced paediatric life support attendance and levels of core skills training among registered emergency department nurses are inadequate. Pressure on staffing capacity has resulted in difficulties in releasing staff for core skills training. Relationships with the social care team based at the hospital are positive and channels of communication and referral are clear. A weekly review is undertaken by appropriately skilled nursing staff of outcomes for children who have accessed the emergency department over the preceding seven days. This review routinely generates significant further contact with other agencies or health services in relation to individual children. This contact does include liaison with community agencies which is prevention focused or is health promotion activity. Analysis of the activity data arising from the reviews and undertaken for this inspection has not identified evidence of children being at risk and the review itself is a positive quality assurance and safety check. However, there are examples of practice at the point of patient discharge which needs improvement and close monitoring with 20 retrospective referrals to social care in the past 12 months, including two children subject to protection plans and six looked after children. Further managerial interrogation of the review activity data to better understand the high number of cases where the reviewing nurse instigates further activity, is warranted. Although raw data has been collected on this activity since its inception in 2009 and is held in the emergency department, there is no collation of the data or upward reporting of this review activity and resultant outcomes within existing RUH NHS Trust clinical governance or LSCB arrangements. The review's efficacy as a performance management tool to ensure continuous improvement, is therefore significantly reduced.

- 32 The information system newly introduced at RUH NHS Trust, does not yet have an effective risk flagging facility which can easily be updated to alert staff to known concerns relating to individual children. Action is in hand to address this but there has been slippage on the target delivery date for autumn 2011 and the likely timescale for resolution has not been identified. This is a different information system to that operating in the children's emergency department which has an effective flagging system valued by staff but the two systems do not communicate effectively.
- 33 Although there is no sexual assault referral centre (SARC) in BANES, where children and young people have been subject to sexual assault, the clinical pathway and current arrangements are well established and effective. The team of paediatricians operates a 24/7 rota and examinations are undertaken as required in conjunction with forensic specialists in a designated facility in children's outpatients which can be accessed out of hours as required. Generally, young people aged 14+ are taken to SARCs in neighbouring authorities, which are in close proximity. Follow up and on-going sexual health and support arrangements are in place and are effective.
- 34 Adult mental health services do not adequately discharge their safeguarding responsibilities. Children's safeguarding issues and Think Family approaches are not embedded within adult health services and a recent survey undertaken by the Avon and Wiltshire NHS Partnership Trust identified that only 80% of the workforce regarded children's safeguarding as a priority. The Adult Mental Health Children's Social Care Protocol does not effectively ensure that appropriate joint visits and assessments are routinely undertaken where there are concerns about the impact of parental mental health upon children. Staff are not trained to appropriate children safeguarding levels. Performance management of safeguarding and hidden harm issues is being developed between children's and adult services. No protocol is in place to ensure smooth transitions from CAMHS into adult mental health services for vulnerable young people. Managers are aware of these issues and are now taking action to address them.

Outcome 11 Safety, availability and suitability of equipment

- 35 There is a large single access point to acute emergency services at RUH NHS Trust with a seating area situated to the side of the reception. Due to the design of the reception desk, reception staff have a very restricted view of the waiting area and door to the department when they are seated. This significantly restricts their ability to observe children in the area and to assess risks to children or potentially to themselves presented by others within the area. Security monitors at the reception are behind reception staff and on the day of the visit, one monitor picture was blurred and obscured.
- 36 Children are fast-tracked to emergency treatment and there is appropriate resuscitation equipment available in a dedicated bay area. Good work has been done to develop sensitive bereavement provision for families and facilities to enable a family to stay with a child on the paediatric ward are in place.

- 37 Access to play therapy services is good and these services have been positively engaged with pre-admission planning for children with disabilities to reduce distress and trauma.

Outcome 12 Staffing recruitment

- 38 Health staff in provider services are CRB checked at enhanced levels on recruitment in line with minimum national requirements. Providers are increasingly building safeguarding statements into job adverts and job descriptions.

Outcome 13 Staffing numbers

- 39 Health visitors and school nurses are being well supported to improve their engagement with safeguarding arrangements, with a focus on improving attendance and the quality of staff reports to case conferences. Health visitors' service development, skill mixing and capacity building is on trajectory to achieve 2015 national staffing targets, being best in the region at 60% currently. The health visitor service is one of the 20 Early Implementer sites for the health visitor service plan from April 2012 and this has resulted in an additional deployment of three whole time equivalent health visitors recently

Outcome 14 Staffing support

- 40 Safeguarding training at levels commensurate with health staff roles and responsibilities is not being delivered across the entire health economy and health commissioners' and LSCB's monitoring of the provision of safeguarding training across health services lacks rigor. Whereas Sirona and Oxford Health staff are trained to appropriate levels and subject to effective oversight by the named professionals within the service, this is not the case in adult mental health or in the maternity services provided by Great Western Hospital Foundation Trust at Princess Anne Wing at the Royal United Hospital. Levels of safeguarding training at RUH NHS Trust do not meet Collegiate minimum safeguarding training requirements and overall the training targets at the hospital lack sufficient drive. While Trust managers acknowledge this deficit and an action plan is in place subject to Trust management scrutiny, this will now be subject to additional support and governance arrangements under the designated nurse.

- 41 Safeguarding supervision is also not established across the health economy as a whole in line with statutory guidance, with varied arrangements in different services. At RUH NHS Trust a system as set out in *Working Together* ensuring planned, dedicated safeguarding supervision is not in place and is a priority area for development. Informal supervision, advice, guidance and support to staff by senior nurses and hospital managers is available in response to daily activity and is valued by staff. Debrief and reflective sessions for both clinical and non clinical staff including ambulance personnel are in place following specific incidents. However, this is not sufficient to comply with guidance or to effectively performance manage practice. Peer review processes are in place for consultants and their teams which are valued and provide supervision opportunities. Safeguarding supervision is well established in community health services and is effective. Three monthly group safeguarding supervision for midwives is in the process of being introduced by Great Western Hospital Foundation Trust following a pilot programme last year, but is at a very early stage of implementation.

Outcome 16 Audit and monitoring

- 42 Commissioning, contracting and oversight arrangements for the delivery of health services for looked after children and the arrangements with Sirona as the provider are insufficient in scope, they do not assign essential roles and accountabilities, and they lack rigor. There is no effective annual health safeguarding and looked after children reporting system which encompasses all health providers and is subject to rigorous challenge and performance oversight by the PCT, Children's Trust and LSCB. Annual reporting for safeguarding and the health of looked after children services does not describe and analyse providers' activity and outcomes for the previous year and does not include any improvement programme for the following year against which improved performance and outcomes can be mapped.
- 43 Performance for immunisations is positive against the England average (74%) although the proportion of children with up to date immunisations was slightly lower in 2010/11 than in previous years (91.7% compared with 94.7%). performance on immunising looked after children is good with 91.7% with up to date immunisations which is significantly above both comparators. Performance on MMR at age 5 has been identified as needing focused attention by health commissioners to deliver improved performance. Human Papillomavirus Vaccine (HPV) performance is improving and there is some benchmarking activity with Swindon to look at how they are delivering on this to improve local performance. Performance on dental checks is poor at 62.5%, significantly below both comparators at 84.3% and 82%. While recent performance is a slight improvement from 52.6% in 2009/10, overall poor performance dates back to 2008/09 and remains a challenge.

Outcome 20 Notification of other incidents

- 44 The PCT, acute and mental health trusts have satisfactory arrangements in place to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC.

- 45 Health staff have a clear understanding of whistle blowing policies in their organisations and report that they are confident that they would be well supported if they needed to use them.

Outcome 21 Records

- 46 British Association of Adoption and Fostering (BAAF) documentation is used for health assessments ensuring consistency of approach. The quality of recording practice and health record organisation is not at an acceptable standard however, making it difficult to track a young person's pathway through health and social care services. Loose documentation in health records gives rise to the potential for key pieces of information relating to an individual child being lost from the record. Documentation is not routinely filed in chronological order and records of health assessments and review health assessments are not consistently filed in the same section of the record. There is no process for case record audit or the quality assurance of health outcomes.
- 47 Strengths and difficulties questionnaires are not routinely shared with health and do not appear in the looked after children's health records maintained by Sirona. The lack of robust information exchange between social care and Sirona, results in strengths and difficulties questionnaires having limited health impact. It is also difficult to derive accurate data for health's performance measurement of the emotional wellbeing of looked after children. Opportunities to use these in health reviews to enable young people to track their personal emotional development over time are being missed.

Recommendations

Immediately

- NHS Bath and North East Somerset and Sirona Health and Social Care should *ensure the timely completion of all health assessments and reviews (Ofsted, February 2012)*
- NHS Bath and North East Somerset and Sirona Health and Social Care should *ensure that actions identified in looked after children health plans are carried out and are robustly monitored. (Ofsted, February 2012)*
- NHS Bath and North East Somerset and Sirona Health and Social Care should ensure that health records for looked after children are subject to routine quality audit.
- Royal United NHS Hospital Trust should ensure that reception staff have an unrestricted view of the emergency waiting area and entrance.

Within 3 months (from report)

- NHS Bath and North East Somerset and Sirona Health and Social Care should *ensure that a designated doctor and nurse for looked after children are appointed (Ofsted, February 2012)*
- NHS Bath and North East Somerset should *ensure that a performance management framework for health providers' safeguarding activity and outcomes is established and that this is monitored routinely through clinical governance and through the LSCB arrangements (Ofsted, February 2012)*
- NHS Bath and North East Somerset, NHS South Gloucestershire and Avon & Wiltshire Mental Health Partnership NHS Trust should *ensure that adult mental health services have appropriate child protection and safeguarding training and related supervision and that performance monitoring of safeguarding practice in adult services is robust (Ofsted, February 2012)*
- NHS Bath and North East Somerset and The Royal United Hospital NHS Trust should *ensure effective performance management of safeguarding processes, practice and recording within the children's acute hospital services and that their effectiveness is reported to the LSCB (Ofsted, February 2012)*
- NHS Bath and North East Somerset, NHS South Gloucestershire, The Royal United Hospital NHS Trust, Great Western Hospital Foundation Trust and Avon & Wiltshire Mental Health Partnership NHS Trust should *ensure that safeguarding training undertaken by staff in health providers is at the appropriate level, is consistent across all organisations and is subject to rigorous monitoring (Ofsted, February 2012)*

- NHS Bath and North East Somerset, NHS South Gloucestershire, The Royal United Hospital NHS Trust, Great Western Hospital Foundation Trust and Avon & Wiltshire Mental Health Partnership NHS Trust should *ensure that all clinical and non-clinical staff in health provider organisations have access to regular, planned safeguarding supervision (Ofsted, February 2012)*
- NHS Bath and North East Somerset should *ensure that general practitioners, the Walk in Centre, pharmacists and all appropriate health practitioners are fully engaged in safeguarding arrangements (Ofsted, February 2012)*
- NHS Bath and North East Somerset, Bath and North East Somerset Council and Sirona Health and Social Care should *ensure that robust clinical governance of health services to looked after children, including those placed out of area, is in place in accordance with statutory guidance (Ofsted, February 2012)*
- NHS Bath and North East Somerset, Bath and North East Somerset Council and Sirona Health and Social Care should *ensure that health staff attend looked after children reviews, where appropriate and that they receive minutes of the review (Ofsted, February 2012)*
- NHS Bath and North East Somerset, Bath and North East Somerset Council and Sirona Health and Social Care should *ensure that the In Care Council is engaged with the development and quality assurance of health services for looked after children (Ofsted, February 2012)*
- Royal United NHS Hospital Trust should ensure that patient information systems operate an effective flagging system to aid risk identification and that internal ICT systems communicate effectively across all departments.

Within 6 months

- *NHS Bath and North East Somerset and Wiltshire, Bath and North East Somerset Council and Sirona Health and Social Care should ensure that an annual looked after children report is prepared and is presented to the health trust boards, corporate parenting board and health and well-being board (Ofsted, February 2012)*

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.