Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Reading Borough Council

Date of Inspection	**6th February 2012 – 17th February 2012**
Date of final Report	**23rd March 2012**
Commissioning PCT	**NHS Berkshire**
CQC Inspector name	**Tina Welford**
Provider Services Included:	**Berkshire Healthcare Foundation NHS Trust** **Royal Berkshire Foundation NHS Trust**

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 .

NHS Berkshire and Reading Borough Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
Contribution of health agencies to keeping children and young people safe	Adequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
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 regional director, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

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:

Commissioning and planning of child and young peoples' health services and primary care are undertaken by NHS Berkshire**,** working in partnership with South and North West Reading Clinical Commissioning Groups (CCGs) and the overall Berkshire West CCG Federation – which includes a GP lead for commissioning children's services.

Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by Berkshire Healthcare NHS Foundation Trust. The acute hospital providing accident and emergency services (A&E) for children is the Royal Berkshire Hospital in central Reading. Maternity and newborn services are also provided by the Royal Berkshire NHS Foundation Trust. Children and families access primary care services through one of 30 GP Practices in the Reading Borough Council area, including the walk in health centre in Broad Street Mall.

Child and adolescent mental health services (CAMHS) are provided by Berkshire Healthcare NHS Foundation Trust (jointly commissioned under a Section 75 arrangement). Services for children with learning disabilities and difficulties and who have complex health needs services are also provided by this Trust, as well as looked after children health services.

The Young Offenders Institute in Reading includes a Health Centre, provided by Berkshire Healthcare NHS Foundation Trust.

Sexual Health Services are provided by the Royal Berkshire Foundation NHS Trust. An outreach sexual health nurse is specifically commissioned to work with vulnerable and at risk young women to prevent unplanned pregnancy. NHS Berkshire commission some designated health services for young people in Berkshire West, called 'Juice Points'. These provide a range of health information and advice but particularly specialise in offering contraceptive and sexual health advice, and are delivered by Royal Berkshire NHS Foundation Trust in partnership with Reading Borough Council youth service and Connexions Service.

Reading is an economically and culturally vibrant large town in central Berkshire. Significant population changes have been experienced in the last 10 years, with increasing numbers of new entrants and a relatively young population overall – nearly a quarter of the population of Reading is under the age of 20 and around 42% of school age children are from a black or minority ethnic group.

General – leadership and management

1. Health organisations have concurrent safeguarding policies and procedures in place, with recently reviewed training strategies. The monitoring of the implementation of these policies is however, too variable. There is good level of engagement and a highly valued named nurse and named midwifery safeguarding team across all health providers. All named and designated professionals have good access to their respective executive lead for safeguarding. There is a named GP in place, the role also covers the other local authority areas within Berkshire and each GP practice has a designated safeguarding lead. The designated doctor arrangements are interim, and as such the role has a low profile. Within all health organisations there is improving partnership working with the childrens' social care staff at all levels. Designated and named professionals are well engaged with the local safeguarding children board (LSCB) and sub groups. There is good senior manager involvement with the Children Trust Board and LSCB, however, there remains a challenge in ensuring that suitable senior health representation is present at all six LCSBs.

2. There is strong engagement and challenge from the joint health and local authority strategic boards, and also health provider trust boards, effectively scrutinising both the annual and quarterly looked after children reports and action plans.

3. There are safeguarding committees within each health organisation, which review both adult and children safeguarding arrangements, these have been subject to recent redesign consequently the effectiveness of their role in raising the profile of safeguarding such as hidden harm across all adult health services is yet to be embedded.

4. Emotional well being service are currently being developed, however, it is recognised that this is not fully in place and that more work is required. The CAMHS and emotional health (tier 2) and the counselling services have only recently been commissioned; it is too early to measure the impact.

Outcome 1 Involving Users

5. Service user feedback is under developed; there are aspirations to improve this especially with the implementation of the You're Welcome quality criteria for young people friendly health service standards in CAMHS and substance misuse services. Parents have been consulted about the development of care pathway information leaflets within accident and emergency services. There is proactive engagement from health with the Reading Families Forum, Parenting Special Children, which the latter highly value, resulting in good involvement in service redesign.

6. Within the looked after children (LAC) health service there is improving user engagement but this does not include care leavers. The impact of this engagement on service design and delivery is not yet apparent. Whilst there has been some flexibility in venue choice for looked after children health assessments, this is not consistently applied. Within the substance misuse services there has been engagement work undertaken with care leavers with positive outcomes for the young people, evidence supported by results from a number of satisfaction surveys.

7. Sexual health and contraception services have undertaken a number of research studies and surveys which have had a positive affect on service redesign and increasing the level of engagement from young people. There is good support provided to young women and their partners at the time of, and post termination of pregnancy. As a result consultation and feedback some practitioners provide ongoing support for up to two years post termination.

8. There is good access to translation and interpretation services, although cultural influences on care, health and well being are less evident in practice. Health staff report a lack of cultural awareness training with awareness raising being very reactive.

Outcome 2 Consent

9. There is good identification, in maternity services, of children on protection plans and looked after young people. This is not the case in A&E where the identification of looked after children and the ascertaining of whom has parental responsibility is not robust. Audits have been undertaken to monitor consent, although these have not included looked after children, which is a missed opportunity.

Outcome 4 Care and welfare of people who use services

10. The health of looked after children; 'being healthy' judgement is inadequate. Health files seen during the inspection were mostly comprehensive and the audits were generally of a good quality. However, the content of health assessments was not robust or inclusive, there was no evident of assessment of emotional well being needs and there was no strength and difficulty questionnaire (SDQ) score or analysis available. All initial assessments are undertaken by a medical practitioner. Review health assessments are undertaken by health visitors or school nurses depending on the age of the child. Not all those children known to disability services will have their annual health review linked to/or carried out at the same time as their disability review, resulting in duplicate assessments and increasing the number of health appointments the child/young person has to attend. Those Reading looked after children placed out of the authority area but within 20 miles and those who are 'hard to reach', receive a good service from the dedicated specialist nurse; however the limited capacity of the post reduces the flexibility afforded to the service users. The post holder is family planning trained (although not a requirement of the post) and able to provide sexual health advice to support these young people, although this was not a commissioned service and the recording of the services provided is not robust.

11. Looked after children (LAC) outcome data (published 2011) shows that dental assessments, immunisation and vaccine rates are at 96.3%, which is above England averages, although health assessment rates are only 85% (below England averages). The local authority data for the year September 2010 to December 2011, used as part of monthly performance monitoring, shows average rates to be, 87.2% of health assessments undertaken on time (target 95%), new looked after children initial assessments undertaken on time is, 62.5% and children under 5 medicals assessments on time rate is 77%, the latter two of which are inadequate. There has been no comprehensive analysis of the low rate of health assessments and refusal rates.

12. Cultural and religious needs were frequently not recorded or assessed as part of the review health assessment. There was no evidence of health education/promotion information being given. There is poor monitoring of health action plans; however, with the introduction of the new information management system plans are well developed to address this. Further, there is no quality control or quality assurance of the health assessments; plans to address this are less well developed.

13. The CAMHS dedicated LAC service is established, however, there is limited support provided to promote resilience and placement stability. When support has been provided, such as with children who have complex needs through joint work with Directions Fostering and long term therapeutic CAMHS input, this has been successful in supporting and maintaining placements. Access to CAMHS has recently improved since the introduction of the 'common point of entry' (CPE) for all referrals, with has improved signposting for those referrals which do not met thresholds. Practitioners have also noted better feedback on the status of a referral, however, there still remains a challenge in receiving ongoing feedback once treatment has commenced. GPs report challenges in receiving intervention and treatment progress reports which previously, although not comprehensive, had been more frequent.

Outcome 6 Co-operating with others

14. Childrens' social care safeguarding referral thresholds are well understood by health professionals. There has been minimal, but successful use, of the escalation policy. The attendance of health professionals at child protection meetings is too variable, leading to poor communication and information sharing, which is further affected by delays in minutes being received. Poor attendance at case conferences is in part due to the fact that school nursing case loads have a high number of children with protection plans, (between 6 practitioners they hold 120 children on protection plans, this excludes all the electronic common assessment framework {E-CAFs} cases and the lead professional role for the ECAF cases). All cases are prioritised but allocation is complicated further by the fact that most of the workforce are on 'term time' only contracts. These high caseloads impact on the universal health work that school nurses can deliver, which is limited. The children community nurses and specialist children's nurses, such as the specialist nurse for diabetic children, do have good working relationships with education staff and are able to provide training to carers, classroom staff and school transport drivers, ensuring that medications and medical emergencies are well managed to maintain the child's health. General practitioners (GPs) are not always able to attend case conferences due to the timing but there have been, on limited occasions, conference meetings held in practices, enabling GPs to attend. The GP case conference report template has been recognised as not fit for purpose and a new improved template is being introduced from another part of NHS Berkshire where it has been used successfully. However, this will not improve attendance at case conferences.

15. The effectiveness of protecting children and young people from harm is well demonstrated within the community health practitioner teams, through the use of the E-CAF, along with other forums such as the team around the child, the joint work with the Children Action Team (CAT), staff in the children centres and the highly valued school consultation meetings which are chaired by member of CAT. However, the limited number and high caseloads of community practitioners and the long waiting lists for some therapy services, for example speech and language at 30 weeks, is having a negative impact of the quality of the provision provided.

16. The Thames Valley wide protocol for missing children is not embedded across all partnerships, including health services, and is not used in the assessment of vulnerabilities as part of the children sexual exploitation, which has the potential to leave children unprotected from harm.

17. The roles of the hard to recruit accident and emergency department alcohol liaison nurses role are highly valued. There is a good range of training provided by Source (the contracted substance misuse services) to health and social care staff (including those in the leaving care team) and foster carers. The service operates an open referral policy as well, accepting referrals from those young people as part of the youth justice system, and those who have been given a police 'youth cannabis warning'. Service users have been able to influence the service delivery and design, such as the' drop-in' health (which includes substance misuse service) and sexual health services within the local YMCA, resulting in higher referral and attendance rates. The service however, is not commissioned to work with young carers or siblings of substance misusers which is a gap in provision. There are good on-going outcome measures in place; however, it is too early to measure the full impact. There is only recent engagement and joint working established with children sexual exploitation services.

18. The current rate of teenage conception remains above England averages at 43.8/1000. The rate of termination of pregnancies is below national averages. Whilst there is good access to a range of flexible sexual health and contraceptive services, the impact on reducing the rate of teenage conceptions is yet to be fully realised, as seen by the slow rate of decline. There has been, through joint work with children social care and the youth cabinet, the development of websites and access to various services such as 'Juice Point' in schools and in various community settings. These provide good information and support on sexual health and other health related matters. There is good access to support and counselling pre and post termination of pregnancy, as well as to services providing terminations for all Reading young women, with some sexual health workers escorting the young woman to her clinic appointment. However, rates of terminations remain below England averages, although there has been no analysis of the reason for this, it is assumed by health staff that it is due to the fact that the young person wishes to continue with pregnancy.

19. The 'POPPY' team provides additional support to pregnant young women, fathers to be (who are teenagers as well), substance misusers, victims of domestic violence/abuse, or those who have mental health needs and/or learning disabilities or difficulties. There is good use made of interpreters and good communication processes are in place with other professionals such as health visitors, high risk transitional care midwives, children centres workers and educational staff. The 'young mums to be' '(YMTB)' programme and 'Care2learn' provide good advice and support for looked after children and care leavers. Through this regular support young women are remaining in education and receiving recognised qualifications, whilst accessing good health support and advice.

20. Whilst there is some use made of CAF and E-CAF some of the health staff working in sexual health and contraceptive services have not received training have no awareness of the CAF processes. There are two highly valued specialists' sexual health outreach nurses who are able to provide fast track contraceptive services for looked after young women, and vulnerable young women and men to prevent conceptions or second conceptions. There is good ongoing support and take-up of long acting reversible contraception (LARC), with good easy access to emergency hormonal contraception. This support structure provided through dedicated staff has enabled and ensured that the 'hard to engage' and those young people with highly risky behaviour are well supported and their risks reduced. There are good partnerships with the youth offending services, and services for parents (including teenage parents) such as the Prevention and Support Service, Multi Systemic therapy (MST) and 'Triple P' parenting programme are increasing parenting skills, preventing reoffending and protecting the young parents and children from harm. There have been a numbers of successful outcomes with young people enabled to find employment or return to education.

21. The sexual assault referral centre (SARC) is out of the Reading authority area. Pathways for referral are not clearly understood by all staff, however, health staff report improving communication with the SARC staff, once a referral has been made. There still remains a shortage of suitably qualified staff to undertake the sexual assault examinations and assessments for children and young people.

22. The identification of cases of domestic violence by maternity staff is not robust, women are not always seen alone, and there is no opportunity given to women to request to speak to the midwife alone, such as through the 'red dot' system. There is no consistent maternity service representative on multi agency risk assessment conference (MARAC). Maternity staff will attend MARAC if they have made a referral; however, referral rates are low. The specialist health visitors and the specialist practitioner for domestic abuse who attend MARAC will communicate and share information. Health visitors report good communication and information sharing of domestic violence incidents from both the police and ambulance services. The named nurses are reported to attend, although there was no evidence seen during the inspection to show that information sharing from these meetings is effective.

23. Unborn baby planning is well established, with good partnership working with other agencies. However, too frequently communication post birth from social care staff as to the status of the removal plans is not effective, with midwives frequently being informed from 'the mother' of the details for taking the baby into care or when they are actually being transferred to a mother and baby unit.

24. The revised CAMHS pathway is yet to be fully embedded; however, health staff and families, including those who have children with learning difficulties and disabilities, all report a marked improvement in the rate of acceptance of referrals and the signposting to other services, when thresholds are not met. The intensive - tier 4- provision is only open five days a week (as a day service), and providing some limited outreach services. If an inpatient bed is required, the young person has to travel out of the area, which can lead to isolation from family and friends. Repatriation is good, with joint care through the use of the care programme approach, if transition to adult services is required. The identification of young carers and of hidden harm within adult health services, not just mental health adult services, has improved from a low base, although it is still not comprehensive and too variable.

25. A transition panel has been established with the aim of improving transition to adult services. Transition to adult mental health and adult learning disability and difficulty services is improving, but there still remain a number of gaps in provision where there is no equivalent adult service. There has been recent successful transitional support provided by health therapy staff to education staff at the local college to enable young people with disabilities to access further education, which had previously not been the case.

26. General practitioners (GP) report that frequently they are made aware of a new foster child in their practice catchment area when the foster carer presents at the practice with the paperwork from social care for a health assessment. GP information systems do allow for looked after children to be 'flagged' which is improving information sharing and awareness of vulnerably within the other practice staff who see the child.

27. There is no health care leaving service or after care service, care leavers are not given a copy of their health history, which is not in line with statutory guidance[1].

28. There is no 'health' delivered foster carer training, or training for staff in the residential children homes, although there has been some training by the substance misuse services to residential care home staff and newly qualified social workers. Community learning disabilities and difficulties health team have provided training to school staff and foster carers on an individual basis, as part of an individual child's care plan, or in some cases as part of a competency based training programme to support the child within education and home settings.

Outcome 7 Safeguarding

29. Contribution of health agencies to keeping children and young people safe is adequate.

[1] Statutory Guidance on Promoting the Health and Well-being of Looked After Children (2009) DH DCSF.

30. All named and designated safeguarding professionals have current job descriptions, with the named professionals being highly valued by health practitioners. There is good access to safeguarding support and advice for all health practitioners. There is regular daily contact from the named nurse at Royal Berkshire Hospital with A&E staff ensuring, along with the paediatric liaison role, that all community practitioners receive notifications of all children attendances. The named nurses review all safeguarding concerns which have been identified and ensure that appropriate referrals have been made. The named nurse also follows up the referrals to childrens' social care to ensure that, all staff, especially those in A&E, receive feedback on the status of the referral. The named nurse supports A&E staff to attend the child protection strategy meetings. The Royal Berkshire Healthcare Foundation NHS Trust named nurse, along with other named nurses, have good access to a range of effective supervision, and have been able to access one to one supervision with the Berkshire wide designated safeguarding nurse. The designated nurse holds regular Berkshire wide 'named' practitioner meetings, although the named GP reported not being invited to these forums, which is a missed opportunity. Individual cases are reviewed at these meetings to identify learning; however, there is a lack of evidence to demonstrate the impact on practice and service enhancement. Named doctors all reported good access to the medical director if and when support is required, however there are variable, and in some cases infrequent, rates of take up of safeguarding supervision.

31. The looked after children designated nurse and designated doctor have recently been recruited and the impact of their roles is yet to be seen. There has been no engagement with the Independent Reviewing officers (IRO), with variable attendance by health staff at LAC reviews.

32. A county-wide child death overview panel (CDOP) is established, however, communication to front line staff is not robust. There has been no assessment of impact of campaigns to reduce child and infant deaths or if the campaigns have increased awareness of risk factors. There is however good monitoring of the death rates. Following the death of a Berkshire young person, (out of the area) as a result there has been dedicated education provision in schools provided by lifeguards, but the impact has not been evaluated, although there have been no similar deaths. The CDOP designated professional, recognises that there is more to do in highlighting the role of CDOP and the local campaigns.

33. The accident and emergency services (A&E) at the Royal Berkshire Hospital, 'self harming' pathway is robust and follows national guidance, with good liaison with the child and adolescent mental health services (CAMHS). The A&E information system is due to be replaced shortly, however, currently looked after children and child in need cases are not 'flagged' on the system, there are no plans in place for this to change with the new system, which is a missed opportunity. Children on a child protection plan are flagged, with childrens' social care providing an updated register every week, although health staff only update the system every two weeks so data is not always contemporaneous. The ascertaining of parental consent has not been audited, although there is now an area on the health record to document with whom the child has attended A&E. The quality monitoring of records is not embedded. There is good monitoring of the use of the pain assessment tool (showing mostly 100% compliance) and the paediatric early warning scores (PAWS) with results on display in the children assessment area for parents/visitors, however, some audit results seen in the children inpatient areas were not always up to date, giving a potentially false impression of the quality of the services provided. There are registered children's nurses on duty when the A&E department is open (7am-2am) and good rates of compliance with safeguarding training, and children's clinical skills including life support training. Safeguarding training within the A&E medical staff is inadequate at 70.27%, partially attributed to the rotational doctors. There is limited safeguarding supervision activity within the department, although there is a system in place for debriefing post a child death, which is inclusive of all staff involved.

34. The notification of attendance at unscheduled care centres, such as the A&E department and out of hour's doctors' services to community and primary care practitioners is good. The quality of the information on the notifications, which include rates of attendance, is mostly good. Whilst GPs register these on the patient's health record, and follow up action is undertaken with the health visitors for the under five year olds. GPs seen during the inspection were unaware of how to refer or whom is their locality based school nurse resulting in no communication or information sharing.

<u>Outcome 11 Safety, availability and suitability of equipment</u>

35. The accident and emergency services at the Royal Berkshire Hospital has a new dedicated children department, although the resuscitation area is within the adult resuscitation area. The A&E department acts as an effective single point of entry for all children and young people to the hospital and since the redesign of clinical pathways has seen a marked reduction in the number of referrals and attendances by children and young people using the services inappropriately, although ambulance emergencies has increased by 30%.

36. There has been a pooled equipment budget with education and the local authority for children with disabilities however, health are no longer part of this arrangement. This has resulted in therapy staff especially finding it increasingly difficulty to arrange equipment and resources to support families with children for have complex needs and very challenging behaviour. Therapy staff report that there still remains a challenge getting equipment funding for children with disabilities who are in main stream school, as opposed to those in special schools, despite some joint funding. At the time of the inspection a medical equipment store was being trialled, which will also provide a facility to 'recycle' equipment.

Outcome 12 Staffing recruitment

37. All staff interviewed confirmed that they had received an enhanced criminal records bureau check (CRB) every three years. Despite guidance being issued by the local authority, some therapy staff had been requested by education staff within schools, to provide assurance of their CRB clearance and professional registration in some cases before undertaking activities with vulnerable children, which can result in unnecessary delays in treatment interventions.

Outcome 13 Staffing numbers

38. Capacity within school nursing and health visiting services is very limited, with school nurses reporting that six staff are holding 120 child protection cases between them. Following the recent workforce review of health visiting, in line with national guidance (A Call to Action, Health Visitor Implementation Plan 2011) it has been identified that there is a 50% shortfall in health visitors. Plans are in place to address this, but have yet to be realised, school nursing service are aware of a review of their service is due to take place shortly.

Outcome 14 Staffing support

39. Safeguarding training compliance rates are variable, with Royal Berkshire Hospital overall rate at 97%, Berkshire Healthcare Foundation NHS Trust level 1 is 71%, level 2, 90% and level 3 being 51%. General practitioner and practice staff rate of compliance is not well recorded, although monitored through contracting; the commissioners understand the rate to be above 80%, although no evidence to support this assumption could be provided. The commissioners are aware that there are safeguarding leads within all practices and those GPs who participated in the inspection confirmed this to be the case. Dental services training compliance rate is 50% with NHS Berkshire compliance rate only 33%, both are inadequate.

40. Staff report that training reaffirms their practice however, there are minimal changes made to practice as a result of training. Learning from serious case reviews and significant incidents are included and information from these is shared during training sessions. Health staff value the mutli-professional and interagency training, with clearer identification of the impact on practice reported, than single agency training. Community health staff from Berkshire Healthcare Foundation NHS Trust reported that since the merger of the organisations, there are a number of barriers which prevent them from attending multi agency training and training organised by the LSCB, namely costs and unclear nomination pathways. The measurement of the impact of training in practice across all health providers and commissioners is not undertaken.

41. There are various models of supervision in place, all staff report that there is good timely access although, overall, there is limited evidence of the impact of supervision changing practice. Audit of the effectiveness of supervision are not routine or comprehensive. All named nurses, doctors and designated staff have access to supervision through a variety of different approaches, this has recently been revised and is being formalised still further.

42. There is no looked after children (LAC) supervision system in place and the designated staff do not have a named supervisor. This limited capacity of the LAC designated nurse impacts on the level of supervision that can be provided to health staff involved in the care of LAC. There was no evidence in the health files seen during the inspection of supervision being used, or of the impact that supervision has had in improving care. Some health visitors discuss LAC cases during safeguarding supervision. The designated nurse for looked after children receives no looked after supervision.

Outcome 16 Audit and monitoring

43. The local authority has reviewed and revised the monitoring of health outcomes for looked after children with the aim of improving rates of compliance, however, this is yet to have an impact.

44. Section 11 safeguarding audits are undertaken and reviewed at the LSCB, which show good rates of compliance. There are a range of action plans in place as a result of audits and incidents which are monitored by the respective trust board on a monthly- quarterly basis however, the impact of the change to the culture and practice is not effectively scrutinised.

45. Royal Berkshire Foundation NHS Trust operates an effective ‘patient safety round’ system, although safeguarding has not been included, this is a missed opportunity.

46. A new information management system has been recently introduced in the community and another system is soon to be introduced in the accident and emergency department, with the aim of improving record keeping and allow for more robust performance monitoring.

Outcome 20 Notification of other incidents

47. Although the role of the local authority designated officer (LADO) is understood, there has been limited use by health organisations of the LADO in investigating complaints. There has been no analysis of the low rates of referral. There is good use of the data from the risk management system at the Royal Berkshire Hospital used to monitor significant incident reporting for all safeguarding concerns, which is effectively monitored with regular reports submitted to the trust board for scrutiny.

Outcome 21 Records

48. The health records seen during the inspection did not all contain concurrent chronologies, in some cases there were very significant gaps of over 12 months. Professional guidance on record keeping was not always followed and there was no evidence of supervision being recorded in the files inspected.

Recommendations

(Those from the joint report in italics)

Safeguarding

3 months

NHS Berkshire and the Royal Berkshire Hospital NHS Trust must ensure that maternity staff ask pregnant women alone if they are subject to domestic violence and ensure that the woman is fully supported.

NHS Berkshire and the Royal Berkshire Foundation NHS Trust must ensure that there is robust engagement of maternity services with the MARAC and there is good communication of case outcomes.

6 months

NHS Berkshire must ensure that all staff are aware of the role and outcomes of the child death overview panel (CDOP).

NHS Berkshire, Royal Berkshire Foundation NHS Trust and Reading Borough Council must ensure that staff in the accident and emergency department are able to promptly identify and 'flag' looked after children as well as those on child protection plans, looked after children and details of whom has parental consent, to ensure the child is appropriately protected from harm.

NHS Berkshire and the Berkshire Healthcare Foundation NHS Trust must ensure that there are sufficient numbers of community practitioners in line with national directives and local needs to provide the commissioned service and universal health child programme.

NHS Berkshire and the local safeguarding children board must ensure that the impact of training on changes to practice to protect children form harm is well embedded throughout all health providers.

NHS Berkshire and Berkshire Healthcare Foundation NHS Trust must ensure a good well planned transition to adult mental health/learning disability services for all young people with a mental health and/or learning disability or difficulty.

NHS Berkshire must ensure that the waiting list to access speech and language service is reduced in line with national directives to ensure that all children have timely access to treatment and interventions.

Looked after children services

3 months

NHS Berkshire, Berkshire Healthcare Foundation NHS Trust and Reading Borough Council must ensure that all health assessments are undertaken within the statutory timeframes, and health needs are clearly identified and addressed.

NHS Berkshire and Berkshire Healthcare Foundation NHS Trust must ensure that all care leavers are enabled to access health services and receive a copy of their health histories to ensure that they can make future life choices.

NHS Berkshire and Berkshire Healthcare Foundation NHS Trust must ensure that all looked after children and young people receives age appropriate health education and promotion information.

NHS Berkshire, Berkshire Healthcare Foundation NHS Trust and Reading Borough Council must ensure that the strength and difficulties questionnaire outcomes are reviewed as part of the emotional health and well being assessment during their review health assessments.

NHS Berkshire and Berkshire Healthcare Foundation NHS Trust must ensure that all health staff involved in the health assessments, care and treatment for look after children have access to supervision.

6 months

NHS Berkshire and Berkshire Healthcare Foundation NHS Trust must ensure that the experience of service users is collected and informs service design and delivery.

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.