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

Date of Inspection	**23rd April 2012 – 4th May 2012**
Date of final Report	**13th June 2012**
Commissioning PCT	**NHS Somerset**
CQC Inspector name	**Jan Clark**
Provider Services Included:	**Somerset Partnership NHS Foundation Trust** **Taunton and Somerset Hospital NHS Foundation Trust** **Yeovil District Hospital NHS Foundation Trust** **Sirona Healthcare, Bath**
CQC Region	**South West**
CQC Regional Deputy Director	**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 .

Somerset County 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	GOOD
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 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:

Somerset is a rural county in the south west of England covering an area of 3,452 km², with a resident population of just over 530,000 of which just over 23% are under twenty. Although there are pockets of socio-economic deprivation, overall the population is less deprived when compared with the national average, although there is recognition that the rurality presents challenges in terms of equity and access to health and social care services. The county consists of five districts, Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset, with one in four people living in the larger towns of Taunton, Yeovil and Bridgwater.

As of January 2012, 7.1% of the school population was classified as belonging to an ethnic group other than White British, compared to 22.5% in England overall. Some 3.6% of pupils do not have English as a first language. Apart from English, Polish and Portuguese are the most commonly recorded first language of school pupils. In 2010 there were 5,671 live births in Somerset and 18% of the county population is under sixteen being in line with the regional and national averages.

Somerset Children's Trust was established in 2005, led by Somerset County Council and currently chaired by a county councillor. The Children's Trust brings together the key agencies responsible for commissioning and delivering services to children, young people and families. The Somerset Safeguarding Children Board became independently chaired in 2009, bringing together the main organisations that provide safeguarding services to children and young people. NHS Somerset has joint commissioning arrangements with the local authority for: adult mental health services, child and adolescent mental health services, substance misuse for adults and for children. Section 75 agreements are in place for the jointly commissioned services for learning disability and the joint equipment service.

Somerset Partnership NHS Foundation Trust provides mental health services, learning disability services, child and adolescent mental health services (CAMHS) and community health services which includes health visiting, school nursing, and integrated paediatric therapy services. The Trust provides 13 Community Hospitals and nine of these include minor injury units (MIU). Taunton and Somerset Hospital NHS Foundation Trust provides acute services including accident and emergency services, acute and community paediatric services, community children’s nursing service, children’s palliative care service, maternity services and level 2 neonatal care for the population of Taunton, Bridgwater, Glastonbury, Shepton Mallet and West Somerset. Yeovil District Hospital NHS Foundation Trust provides acute services including accident and emergency services, acute and community paediatric services, community children’s nursing service, maternity services and level 1 neonatal care for the population of Yeovil, South and East Somerset, and North Dorset.

Some outpatient services for children are provided from community hospital sites. NHS Somerset is an associate commissioner for the Royal United Bath Hospital NHS Foundation Trust, which provides the acute services including acute paediatric services for the Mendip area of Somerset. Community paediatric services in this area are provided by Sirona Healthcare.

Children and their families access primary care services through one of seventy-six GP practices. In Yeovil there is also a GP led health centre which provides care for registered patients and also provides a Walk in Centre. General dental services for children are provided by 86 high street dental practices, contracted to provide NHS services across Somerset. This general service provision is available to looked after children and to children who have disabilities, depending on the practice facilities and a child's individual need. The primary care dental service provides a community dental service to specific user groups who are unable to access general dental services. The service is concerned with providing and enabling the improvement of oral health of individuals, including children and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability. This includes at risk, deprived and looked after children.

Children's palliative care services are provided by the compass team hosted by Taunton and Somerset NHS Foundation Trust for the population of Somerset excluding the Mendip area. The compass team is supported by provision from the community children's nursing services provided by both Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. Children's palliative care services for the Mendip area are provided by the lifetime service which is part of Sirona Healthcare, Bath. A service specification for a new child centred, life long continuity of care palliative service model has been developed and negotiations are in progress with the trusts for implementation.

NHS Somerset jointly commissions short breaks for children with complex health needs through the Somerset children's complex health needs panel. Care packages are commissioned from the Taunton children's homecare team provided by Taunton and Somerset NHS Foundation Trust, Barnado's Family Link, jointly commissioned service and direct payments. The care pathway is implemented in line with the National Framework for Continuing Care for Children and Young People DH 2010.

Young people's substance misuse services are commissioned by the Somerset drug and alcohol partnership (SDAP). This includes Somerset County Council, Somerset Primary Care Trust, Avon and Somerset Constabulary, Avon and Somerset Probation and district councils. The children's trust and SDAP have established a shared subgroup, the young people's substance misuse commissioning group, which focuses on commissioning young people's substance misuse services. The specialist young people substance misuse service (SMS) is provided by Somerset Partnership NHS Foundation Trust as part of CAMHS.

The Health and Wellbeing Board will provide a forum for local commissioners across the NHS, public health and social care and representatives of Healthwatch to discuss joint working to provide better health and wellbeing outcomes for the people of Somerset. As an early implementer the shadow Somerset Board is responsible for overseeing the development of the fully constituted Health and Wellbeing Board for Somerset. Currently it its shadow form it reports to Somerset County Council and the Primary Care Trust Board.

At the time of the inspection there were 495 looked after children. They comprise 122 children less than five years of age, 313 children of school age (5–16), 60 young people aged 16+ and there are 108 with care leaver status. There were 282 children who were the subject of a child protection plan. The highest categories of registration were neglect at 27% and emotional abuse at 25%, physical and emotional abuse at 16% and neglect and emotional abuse at 14%, 43% have multiple categories.

General – leadership and management

1 The overall effectiveness of children's safeguarding arrangements in Somerset is adequate. However, health's contribution to safeguarding is good. Frontline health staff have access to safeguarding policies and procedures to guide their day to day practice. Both clinical and non-clinical staff across the health community as a whole have a good understanding of risk indicators and their safeguarding roles and responsibilities. The child death overview panel (CDOP) is effective and practice is continuously improved by lessons learnt from research and national and local incidents. NHS Somerset's performance management of safeguarding activity is robust with safeguarding children standards included in contracts for all foundation trusts and independent providers. The designated doctor and designated nurse provide strong supportive leadership and rigorous challenge to providers. All staff in the health provider trusts have good access to knowledgeable named and designated professionals who are leading practice development and performance improvement well.

2 While it is evident that health and the local authority have clearly prioritised safeguarding and child protection services, the delivery and provision of services for looked after children are comparably weaker. This is particularly evident in the delivery of the Being Healthy outcome for looked after children which is inadequate.

3 There has been insufficient rigor in the PCT's and multi-agency healthy care partnership's management and oversight of service delivery to looked after children by the community health service provider, now part of Somerset Partnership NHS Foundation Trust (SPFT). Service deficits were identified just prior to the inspection and remedial action, including allocating management oversight of the service to the safeguarding named nurse, is being taken through an initial action plan and a whole system review led by the PCT. These actions are too recent to have had measurable impact and although there are committed and diligent workers within the looked after children health team, there are significant deficits within the service.

4 There is no clear, whole system approach across the health and social care partnership to the provision of health care to looked after children. There is a lack of connectivity and effective communication between the looked after children health team and the independent review officers (IROs). The annual IRO report does not address the provision of health services for the looked after children cohort and there is no IRO representation on the healthy care partnership which oversees health service delivery for looked after children.

5 NHS Somerset share a clear ambition and appropriate priorities for children and young people with the local authority and other partners set out in the Children and Young People's Plan (CYPP) for 2011-12. However, the joint inspection found limited clarity in terms of how these will be achieved by the partnership, particularly within the context of how the council is to achieve future budget savings. The turnover of senior managers in the local authority has also been substantial and this, added to the wider reorganisation of the council, has inevitably led to some loss of drive to the joint improvement agenda. The revised joint strategic needs assessment (JSNA) provides a useful profile of children and young people's needs and is a sound platform of information and intelligence upon which the partnership can evaluate achievement.

Outcome 1 Involving Users

6 Young people are having a positive influence on how PHSE services are being provided in schools with involvement in steering groups in the schools where each clinic is operating. The service aims to have at least one looked after child and one vulnerable child on each steering group. Services are flexible as far as possible offering some choice of gender of worker and some access to services at weekends in Yeovil although most schools based clinics operate during lunchtimes due to transport and rurality issues. Young people have been very involved in the innovative development of the Somerset sexual health app for smart phones giving information about service availability and access. This very successful development is to be rolled out as an android application. Young people's participation is also central to the developing young people project. Sexual health services are accredited under "young people friendly" criteria.

7 For children with disabilities, service user consultation was undertaken as part of the paediatric therapy service review process. In total 132 questionnaires were returned and five focus groups were held across Somerset. Four questionnaires were completed by carers, with the remainder being completed by parents. This led to the development of the new integrated paediatric therapy service specification and the new structure and service model provided by Somerset Community Health (subsequently acquired by Somerset Partnership NHS Foundation Trust). The integrated paediatric therapy service has been in place since January 2010. Key Performance Indicators have been agreed in liaison with providers and parent representatives and are monitored at a quarterly contract meeting attended by the PCT as lead commissioner, provider managers and parent representatives. The service has achieved significant reductions in waiting times, previously as long as two years. By February 2011, 98.5% of children on the waiting list had waiting times of 18 weeks or less. This compares very favourably to a figure of 87.5% in March 2010 and 41% at the inception of the service.

8 Young people engaged with the substance misuse service set and evaluate their own goals and treatment objectives.

9 There is scope to develop and strengthen the involvement and participation of young people who are looked after in their health assessments and health reviews. The voice of the child or young person does not always come through strongly and should be evidenced more consistently. Older looked after children are not routinely signing their own consent to the assessment.

10 Support to care leavers is under developed. Substance misuse among this cohort is high and there are no clear strategies to address this need. Care leavers have not recently been involved in the development of health information to support a young person leaving care and they are not given a health history. Looked after children and the Children in Care Council are not sufficiently engaged in developing and delivering the agenda for how the health needs of looked after children are being addressed. There is no mechanism in place by which young people will be facilitated in holding health to account for the health elements of the Pledge. Young people have also not been involved in the recruitment of key health personnel and to date there have not been regular meetings between the looked after children health team and the Children in Care Council, although these are planned for the future.

11 Health staff across services report good access to interpretation and translation services and there is a growing awareness and understanding of cultural issues within different minority ethnic communities beginning to reside in the area. Information is provided in different formats and languages. Some health teams, such as the maternity services benefit from a range of language skills within the team. Approximately 20 vulnerable women encompassing asylum seekers, homeless and victims of domestic violence are currently benefitting from the acorn project.

Outcome 2 Consent

12 The looked after children health service provided by the partnership trust did not demonstrate compliance with Department of Health guidance in regards to the provision of parental consent to treatment. In the single case seen where a parental consent to treatment form had been passed to the health team, it was wrongly completed rendering it invalid.

Outcome 4 Care and welfare of people who use services

13 Considerable progress has been made in reducing teenage pregnancy overseen by the multi agency Somerset teenage pregnancy partnership board. In 2010 Somerset had an under 18 conception rate of 29.2 per 1000 young women aged 15 – 17 years old. This represents a 2.7% decrease on the 2009 rate and a total reduction of 24.7% since 1998. This compares well to a rate of 29.9 in the South West. During 2010-11 the number of teenage mothers was 1.7% which is similar to the England average.

14 The recent CQC unannounced inspection of Musgrove Park Hospital's termination of pregnancy service found the provider to be non compliant with Essential Standards for Records Outcome 21 in relation to the use of the HSA1 form. An action plan is in place, subject to management oversight and on-going engagement with CQC.

15 The substance misuse service for young people is small, consisting of four workers integrated into the CAMHs teams in each area of the county. Access is straightforward with self referral as an option and young people are seen within five days. Some effective preventative work is undertaken in partnership with the targeted youth support team. Of the 43 young people starting new treatment journeys with the specialist substance misuse service, six were looked after children. The number of looked after children who had been looked after for at least 12 months at 31st March 2011and identified as having a substance misuse problem was 36, representing 12.1% of all long term looked after children. The number receiving an intervention was 24 (66%) of those who were offered an intervention with 11 refusing intervention. Substance misuse among the cohort of care leavers is high and there are no clear specific strategies to address this need, neither is there sufficient support to care leavers who have mental health concerns.

16 The small child and adolescent mental health services (CAMHS) provides a limited access service although once engaged with services, outcomes for young people are positive. Thresholds for service are perceived in referring services as high or unclear and this should be addressed. Further review of the CAMHS care pathway has been initiated by the CAMHS Commissioning Group, this will include to review the referral pathways and access to Tier 3 services. Health visitor and school nurse workforce development is also expected to increase capacity for support at Tier 2 and 3. There is scope for further engagement between services to raise awareness of what different services provide and ensure referrals are appropriate.

17 A multi-agency transitions group meets routinely to over see transition arrangements and no operational difficulties in transitions from children's into most adult services have been identified by the inspection. Recovery workers operate across CAMHS and the adult service which provides continuity and a number of case examples with positive outcomes were cited. Operational staff working across the interface report that arrangements work effectively for most young people, although there is a recognised gap for young people with Asperger's syndrome of which commissioners are aware and transitions into the adult drug and alcohol service are not always seamless.

18 Where young people need inpatient treatment for mental health problems, there is access to Tier 4 beds in the specialist inpatient unit at Wessex House in Bridgwater with a notional five inpatient beds provision for Somerset patients. Admissions to adult wards are rare, although this has occurred twice in the last year. On both occasions, these were well considered, planned admissions to meet the specific safety and complex needs of the young people and the admissions were closely monitored through clinical governance and were of brief duration.

19 Prior to October 2009 there was a significant difference in the experience and outcomes for children with disabilities and their families engaged with the separate paediatric occupational therapy, physiotherapy and speech and language therapy services. Only 41% of referrals were seen within 18 weeks with some children waiting up to two years and the number of complaints concerning the service was unacceptably high. Operating since January 2010, the integrated paediatric therapy service achieved a waiting time of 18 weeks or less for 98.5% of referrals in February 2012 against an expected standard of 95% by 31 March 2012. The inception of a telephone advice line is a positive development valued by other professionals and accessible to carers to provide support prior to intervention. The multi-agency intervention service for early years (MAISEY) is providing an effective 'team around the child' forum and there are examples of how early intervention has been effective in sustaining children with disabilities at low level of support. Clinical interventions are also increasingly being co-ordinated to reduce the trauma and complexity of arrangements for individual children with examples of positive outcomes being given.

20 Children who are entering the care system do not routinely have access to a timely, comprehensive health needs assessment completed within the expected 28 days of them becoming looked after. Performance on the undertaking of initial health assessments within timescales is poor with one child in the case sample waiting five and a half months for an initial assessment. There is a significant risk therefore that some children may not have their health needs identified and addressed during a care episode. Reasons for delays are not recorded, although there are significant, recently identified, clinical capacity problems now being addressed as part of the service review. Performance on undertaking review health assessments completed for children in care who have been looked after for twelve months or more presents a more positive picture at 248/286 (86.7%) at the end of March 2011. With adjustment for sixteen children and young people who have declined the health assessment, this equates to 248/270 (91.9%). Initial health assessments are undertaken by a range of appropriately qualified health professionals, including GPs where appropriate, under the direction and oversight of the designated doctor. No effective quality assurance process is in place encompassing the monitoring of the quality of health assessments, which is variable, and whether the child's identified health needs have been met.

Outcome 6 Co-operating with others

21 Health are well represented on the infrastructure of the LSCB, having the designated nurse as a member of these sub-groups; audit and policy, children with disabilities, missing persons/independent providers, e-learning and the safeguarding board executive reviewing and contributing to audit and board policy development. The child death overview panel has wide health representation and is chaired by Public Health. It reports regularly to the LSCB and has received positive feedback from government on how the interface between child death overview panel (CDOP) reviewing process and serious case reviews (SCR) is operating.

22 Lines of communication between health agencies and social care are consistently described as constructive, open and robust. Escalation arrangements are well established in the event of challenges or disagreements between agencies, through local managerial arrangements to ensure services respond in accordance with agreed protocols. These operate effectively. Looked after children health staff report regular communication with social workers, health visitors and school nurses in relation to individual children, although there is not strong evidence to support this on case records. Health visitors and school nurses do provide a range of health promotion activities and information on an individual and group basis in schools and residential homes. They undertake health reviews where children are placed locally and will attend statutory looked after children reviews as appropriate.

23 Systems and processes are not sufficiently rigorous to ensure that children placed out of area consistently receive healthcare which addresses all their needs. Recent actions have been taken to strengthen governance arrangements in relation to looked after children through strengthening the multi-agency Healthy Care Partnership which oversees arrangements for improving the health of looked after children. This has recently included members with responsibility for child and adolescent health, teenage pregnancy and young people leaving care.

24 Action is being taken to ensure improved quality of health provision and outcomes for looked after children placed out of area. These actions are based on the strong safeguarding approaches overseen by the named safeguarding nurse in the provider trust who now has management oversight of the looked after children service; these include direct contact between Somerset named safeguarding nurses and their counterparts in placement areas where issues of poor quality health delivery have been identified.

25 The common assessment framework (CAF) is not well embedded and consistently applied across the partnership. The local authority is, however, currently reviewing the use and impact of CAFs within Somerset with view to strengthening their impact on outcomes for children and young people. The local authority has full support from partner agencies and the voluntary and community sector regarding this review.

26 Health staff are routinely involved in child protection case conferences. Their contribution is valued and they feel part of the decision making process, leaving conferences clear on their role and responsibility in the protection plan. Health visitors and school nurses prioritise child protection and safeguarding activity and work well in partnership with other professionals. Attendance at child protection conferences is good and subject to close monitoring through Somerset Partnership NHS Foundation Trust's governance arrangements. Where attendance has been less than 100%, due to staff sickness and vacancies, actions have been taken to address this through the incident reporting process.

27 The range of substance misuse and sexual health services including the well established contraception and sexual health (CASH) branded service, operate effective partnerships with social care, schools, the youth service and youth offending. They provide flexible and responsive outreach services resulting in positive outcomes. As a result of these positive partnerships, the incidence of teenage pregnancies has been successfully reduced to significantly below the national and regional averages.

28 An integrated healthy child service model has been established based on the healthy child programme. Health visitors and children's centres work together to provide services which are effective in supporting children and families, including teenage parents and children in need. There is positive operational partnership working.

29 Designated professionals meet regularly with social care senior managers and dialogue is constructive and solutions focused. Additionally, community health service named nurses meet regularly with children's social care managers and team leaders to identify and resolve operational issues which may impede effective multi-agency collaborative working.

Outcome 7 Safeguarding

30 Both the designated doctor and designated nurse for safeguarding are highly effective in their roles. They are well regarded members of the LSCB, provide a strong point of leadership and support for safeguarding professionals in all provider services as well as ensuring the delivery of lessons learnt from SCR. They continually challenge providers to demonstrate continuous improvement and have established robust performance monitoring arrangements. Examples of good work include; all Minor Injury Unit nurse practitioners receiving extra level 2 training in the recognition of the clinical signs of child abuse and neglect, delivered by the designated doctor as a result of a recent internal health community review. Also, there are robust and extensive briefings, training materials and performance audit activity designed to establish and monitor the effectiveness of learning and changes made as a consequence of serious case reviews, including key learning prior to the publication of reviews. The designated nurse had delivered a detailed debriefing on a recent case at a multi-agency event just prior to the inspection which had been well received by attendees.

31 Frontline health staff have access to safeguarding policies and procedures to guide their day to day practice. All health staff have access to the web-based shared South West child protection procedures from a link on the Somerset safeguarding children website. There is good access to knowledgeable designated and named professionals within the provider services who are leading practice development and performance improvement well. There are well used escalation arrangements in place in the event of challenges or disagreements between agencies, through local managerial arrangements to ensure services respond in accordance with agreed protocols. Lines of communication are consistently described as constructive, open and robust.

32 Safeguarding arrangements and systems to identify potential safeguarding risks to children are well established at both the acute hospitals and Minor Injury Unit (MIU). Named nurses undertake daily reviews of under 18 year olds presenting for treatment and this activity is reported regularly thorough clinical governance arrangements. The introduction of protocols for action following young person (0-19) presentation at A&E, the walk in centre (WIC) and MIU and for working with fathers and other male carers in Sept 2011is innovative and evidence from audits demonstrate good understanding and knowledge of both protocols among staff across services. Overall, service compliance with the protocol for working with fathers and other male carers is at 90% with an overall compliance of 94% for the protocol for action Following a child/young person (aged 0 – 19 years) attendance at A&E departments, MIU or WIC. All provider services are closely engaged with multi-agency risk assessment conferences (MARAC) and able to cite examples of cases of early preventative intervention as a result of effective MARAC arrangements. The serious concerns meeting, which is part of this multi-agency framework and which involves the matron from the A&E at Yeovil District Hospital, facilitates these positive outcomes. Information systems operate flags where there are known concerns or issues of frequent attendance with a new system in development at Yeovil. Staff at the various acute services communicate routinely with colleagues at other sites to alert them to children being referred to their service to ensure non arrival is acted on.

33 Midwives within the maternity services have a good awareness of safeguarding risks and what indicators to look for. Access to individual safeguarding supervision, in addition to group sessions, is in place. Effective pre-birth planning with social care routinely takes place in a multi-agency approach and an effective missed appointments policy is in place. Any difficulties in engagement with social care are addressed promptly by the named midwife. There is increasing awareness across maternity services of cultural issues in some communities including attitudes to children born with disabilities. Midwives have received CAF training but the use of CAFs is limited.

34 GP engagement in safeguarding arrangements is currently under developed although it is improving. A report template has been developed to facilitate consistent contribution to case conferences although this is not used by all practitioners. Each practice has an identified safeguarding lead, and uptake of training is monitored. The named GP is working closely with the designated safeguarding doctor and nurse to strengthen engagement. GP engagement is being addressed through appraisal although there is scope to strengthen this further. There is more to do to improve attendance of GPs at conferences. There is not yet an established GP safeguarding practice development forum although this is being initiated as part of the new clinical commissioning group federation infrastructure. Currently, safeguarding training for GPs has been set at level two, whereas many LSCBs nationally are now setting the bar at level 3. This is to ensure GPs and other primary care practitioners have sufficient understanding of the potential risks of hidden harm to children when the primary patient may be an adult with drug and alcohol issues or mental ill health. The effectiveness of LSCB communication with primary care professionals was mixed with some practitioners feeling clear on LSCB expectations and who to contact if they identified safeguarding concerns, while others are much less well informed. The PCT and LSCB have not yet sufficiently engaged dentists in safeguarding arrangements with this being at an earlier stage than for GPs.

35 Arrangements are in place to guide adult service workers in identifying children at risk of hidden harm in a household where an adult is accessing mental health, adult disability or substance misuse services. There is close liaison between safeguarding leads in adult and children's services to ensure effective working. Assessment documentation contains triggers and child safeguarding is routinely discussed in supervision and team meetings. Joint work is undertaken by children's and adult workers in response to individual need or where a protection plan is in place. The trust practice standard is that all patients for whom there are safeguarding concerns, as a victim or perpetrator, will be clearly identified on the patient records. In the practice standards audit undertaken in April 2011 there was 100% compliance for this standard.

36 For young people who need to access forensic sexual assault services, NHS Somerset in partnership with NHS Bristol commissions the sexual assault referral centre (SARC) service through the Bridge SARC service in Bristol. Improvements to the care pathway for children and young people have been made following a recent incident involving a Somerset patient who was not able to access the service although appropriate treatment and care was accessed from the local paediatric service. This has resulted in the development of agreed revised protocols and understanding that the SARC can provide an effective outreach service to see children and young women in Somerset which may be more appropriate than travelling to Bristol. Follow up support and sexual health services are in place. Access to sexual assault examination and treatment, not requiring SARC provision, is provided effectively by appropriately qualified and skilled paediatricians at Musgrove Park Hospital and Yeovil District Hospital.

Outcome 11 Safety, availability and suitability of equipment

37 The environment at Yeovil District Hospital emergency department is child friendly with a separate children's waiting room and a range of toys and distraction equipment accessed from a single adult and child reception point. Waiting areas have a wide range of information on services displayed. A separate quiet room is available for young person demonstrating emotional distress or for young people with challenging behaviours to minimise the impact of the department as it is quite small and crowded, presenting a potentially challenging environment when busy. The separate resuscitation area for children is appropriately equipped and maintained. A separate relatives' room is well appointed and sensitively decorated.

38 Victims of sexual assault not requiring SARC provision are referred to the paediatric ward where colposcope equipment is available and forensically trained paediatricians operate a specialist service.

39 Musgrove Park Hospital, Taunton & Somerset NHS Foundation Trust also has a single reception point for emergency treatment with well equipped separate children's waiting area. Work is in progress to expand the resuscitation facilities to provide a separate children's bay, not currently provided. The relative's room is well situated within the department, close to resuscitation and treatment areas.

40 Provision of equipment to children with disabilities or life limiting conditions in the community works well enabling children to access mainstream schooling and services in accordance with parent's wishes whenever possible. Effective multi-agency planning for mainstream service entry and early funding for equipment is facilitated by the MAISEY meetings held every half-term.

Outcome 12 Staffing recruitment

41 Health staff in provider services are CRB checked at enhanced levels on recruitment, in line with minimum national requirements and attention to safer recruitment practice is good. All Somerset community health managers are required to undertake managing allegations against staff training. A small number of Somerset Partnership NHS Foundation Trust (SPFT) operational managers have attended the Safer Recruitment Training provided by the LSCB. The safeguarding lead has provided safer recruitment training to all of the trusts human resources team. A "managing allegations against staff " policy has been in place since March 2011 and is available to all staff on the intranet site with awareness also being promoted through newsletters and staff briefings. During the course of the year SPFT notified the local authority designated officer (LADO) of two investigations relating to staff working with children where safeguarding concerns had been raised. Both cases resulted in further training and one of the cases to redeployment.

42 In Taunton & Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, CRB checks are completed on all members of staff. The Trusts have a 100% compliance rate for all staff including those employees that require an enhanced check.

43 Yeovil District Hospital NHS Foundation Trust undertakes criminal record bureau checks for all staff employed within the Trust who will have access to patients and the public. The Trust also has a programme in place for undertaking checks for staff who were employed prior to criminal record bureau checks coming into practice.

Outcome 13 Staffing numbers

44 The delivery of 'Call to Action' is being prioritised by both the PCT and the Somerset Partnership NHS Foundation Trust. Targets for health visitor workforce growth and development as well as the numbers of students to be trained are set out clearly in the service contract. A health visitor workforce steering group is in place to oversee the delivery of the new service model and achievement of 2015 targets. Two health visitors are also currently attending the SHA leadership course

45 The service is also building capacity through skill mixing and adopting family nurse partnership practice as part of the health visitors' core skill set to strengthen the work with teenage parents and children in need. Recruitment is buoyant and the service is on track to achieve the 2015 workforce development targets for an additional 37 posts.

Outcome 14 Staffing support

46 Safeguarding training of health staff across the health community at the levels appropriate to their role is in place and take up is good. Performance on training uptake is rigorously monitored through provider trusts, the designated nurse, designated doctor and the LSCB through a sub-group. Training, supervision and support forums, locally and regionally are in place for the designated and safeguarding leads across services and all safeguarding leads are well engaged with arrangements. The health advisory group chaired by the designated nurse monitors all health providers' training delivery and uptake as well as ensuring multi-agency training meets local needs. The group oversees policy and practice development across the health providers and also provides a forum to discuss national guidance, new initiatives and share best practice and expertise on safeguarding issues which the safeguarding leads cite as valuable.

47 Uptake of safeguarding training for Somerset Partnership NHS Foundation Trust is good, being Level 1 87%, level 2 87% and level 3 97%. The audit undertaken in Sept 2011 demonstrated that the majority of Somerset Partnership NHS Foundation Trust staff members last attended child protection training in less than 12 months with no staff attending longer ago than 24 months. This compares well against the previous audit in 2009/10 where 77% of staff attended in less than 12 months, compared to 86%in 2010/11.

48 The provision of regular, planned safeguarding supervision as set out in Working Together to Safeguard Children (2010) is not yet established across the entire health community, however. It is well established on an individual worker basis in community health services for health visitor and school nurses. Taunton and Somerset NHS Foundation Trust have a formal monthly supervision process in place, as well as ad hoc and organised debriefs. Group supervision is in place for community and hospital based midwifery services although there is scope to increase the frequency of these sessions to ensure currency with operational practice issues. Reflective sessions for individuals and staff groups across all services are promptly provided by named professionals in response to requests or specific events and guidance is routinely available and valued. Work is in place to strengthen supervision arrangements for clinical and non-clinical staff in disability and acute services.

Outcome 16 Audit and monitoring

49 The annual NHS Somerset safeguarding report sets out a comprehensive review of comparative performance on safeguarding activity over the previous three years by all health provider trusts. Areas for further development are clearly set out with a measurable improvement plan for the following year. NHS Somerset has a robust approach to the performance monitoring of safeguarding children arrangements in all commissioned services with safeguarding children standards included in contracts for all foundation trusts and independent providers. Procedures in health providers governing children's non-attendance at health appointments have been strengthened and are closely monitored since the 2010 audit identified deficits in some providers. Multi-agency audit activity is valued and prioritised and positive use is made of the learning and outcomes from these audits.

50 The integrated paediatric therapy service has been in place since January 2010. Key performance indicators have been agreed in liaison with providers and parent representatives and are monitored rigorously at a quarterly contract meeting attended by the PCT as lead commissioner, provider managers and parent representatives. The service has achieved significant reductions in waiting times, which had been as long as two years, attracting a high number of complaints in the past.

51 No effective quality assurance process is in place encompassing the monitoring of the quality of health assessments however, and whether the child's identified health needs have been met. Systems and processes are not sufficiently rigorous to ensure that children placed out of area consistently receive healthcare which addresses all their needs. Recent actions have been taken to strengthen governance arrangements in relation to looked after children placed out of area.

52 Performance on the reviews of health assessments for children in care for more than 12 months has been prioritised and is now much improved and is good at over 90%, compared to the England average of 84%. There is also good outcome delivery for universal health outcomes, for example the percentage of dental checks completed for 2010/11 at 90.9% with 2.7% refusing. This is higher than statistical neighbours and England and uptake of primary immunisations is good at 97.8%.

53 The general health and well-being of children in Somerset is mixed compared with the England average and improving performance on the delivery of universal health outcomes is being prioritised and subject to clear strategies. In 2010/11 of the children in reception, 8.7% were obese compared to 9.4% in England and 16.6% of children who were in year six, compared to 19.0% in England. The infant mortality rate was 3.6 per 1,000 live births (2008-2010) similar to England average and the child mortality rate is better than the average. The current MMR uptake is 94.2, compared to an England average rate of 89.1 %. Performance against local and national targets is closely monitored on a monthly basis. To reduce the incidence of measles and mumps targeted work includes raising awareness with GP practices, a catch up programme where immunisations have been missed and opportunistic vaccinations such as checking uptake as part of the school leaver programme.

54 NHS Somerset strategy links with the Healthy Child Programme. In 2008-2009 the number of decayed, missing or filled teeth was 0.8% higher in children in Somerset than the England average. Positive initiatives have been taken to raise awareness in schools including a dental health pilot involving thirteen schools and 322 children in 2011using a postcard competition. In the initial evaluation, dental practices involved reported four new child dental registrations and subsequent impact continues to be monitored.

55 There is a strong partnership approach to addressing issues of substance misuse among the general population of young people. During 2007-10, hospital admissions due to alcohol specific conditions per 100,000 were identified as 73.8 higher than the England average. The proportion of under 18s admitted to hospital for alcohol specific conditions is also increasing in Somerset, with Taunton Deane having the second highest rate in the South West. Health commissioners are working closely with schools and other partners, undertaking a number of surveys to gain a detailed understanding of the substance misuse issues within the under 18 population in order to best inform strategies to address the issue. Targeted educational dramatic productions have been delivered in schools as part of the partnership's response. After seeing recent education productions, school children have said they are less likely to drink alcohol as a result of seeing the productions and a large majority of audiences would either not use cannabis as a result or would not use it anyway. However, incidence of substance misuse in the looked after children cohort is high at 12% and the service response to this is underdeveloped. The absence of specialist CAMHS or substance misuse service provision for looked after children or fast track pathways when a need for support is identified is likely to result in poor outcomes for these highly vulnerable young people and should be addressed.

Outcome 20 Notification of other incidents

56 No issues have been raised during the inspection in relation to notifications. Currently NPSA data definitions for moderate and abuse (which includes notifiable incidents as defined by the regulations) are broad. New guidance is to be provided to trusts reiterating the definitions of classifications following the NHS commissioning body taking over control of NPSA.

Outcome 21 Records

57 Health records maintained by the looked after children health team are poor, containing only very basic information such as the health assessment, where this has been completed, and basic correspondence. It is difficult therefore, to follow the child's pathway through health and social care. Although looked after children health staff report regular communication with social workers, health visitors and school nurses, this is not evidenced in case files and while the voice of the child comes through in some reviews this is also not consistent. Although the looked after children health team have access to the social care information system, no social care information, such as copies of statutory looked after children reviews, is held on the health record.

58 There are no health chronologies and no information as to the reason the child came into care and, as a result, health professionals undertaking health assessments and reviews may not have all the necessary information likely to impact on the child's health and well-being. The lack of health chronologies also does not facilitate the development of useful health histories for young people who are care leavers. Health plans are unsatisfactory with no clear identification of overall objectives or who is responsible for actions or timescales for delivery, which makes monitoring of delivery by social care and the looked after children health team difficult.

59 Strengths and difficulties questionnaires are not used by the looked after children health team to monitor children's emotional development and neither are they used to inform health reviews. Opportunities for the young person to use them as a tool to evaluate their own emotional growth and development are therefore also lost.

Recommendations

Immediately

- *NHS Somerset, Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation and Somerset Partnership NHS Foundation Trust and the council should ensure that all looked after children have access to timely, comprehensive health assessments leading to quality assured health care. (Ofsted June 2012)*

- *NHS Somerset and Somerset Partnership NHS Foundation Trust and the council should ensure that looked after children and care leavers are fully engaged in the development and delivery of the Being Healthy agenda and health elements of the Pledge. (Ofsted June 2012)*

Within 3 months (from report)

- *NHS Somerset and Somerset Partnership NHS Foundation Trust and the council should ensure that looked after children and care leavers have prompt access to specialist health care services including mental health and substance misuse services as required (Ofsted June 2012)*

- *NHS Somerset and Somerset Partnership NHS Foundation Trust and the council should review thresholds for prioritising timely interventions for children with emotional and mental health difficulties by the CAMHS. (Ofsted June 2012)*

- *The local safeguarding children's board (LSCB) and NHS Somerset should ensure that general practitioners (GPs), dentists and all appropriate health practitioners are fully engaged in safeguarding arrangements and have regular developmental opportunities for practice reflection and learning. (Ofsted June 2012)*

- NHS Somerset and Somerset Partnership NHS Foundation Trust should ensure the optimum use of strengths and difficulties questionnaires in the provision of the health and wellbeing of looked after children, including their use by young people as appropriate.

- NHS Somerset and Somerset Partnership NHS Foundation Trust should ensure that health case records are kept to a satisfactory standard and subject to routine quality assurance audit.

- NHS Somerset and Somerset Partnership NHS Foundation Trust should ensure that parental consent for health assessment and treatment for looked after children is recorded appropriately and compliance with national guidance is demonstrated.

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.