REPORT TO THE HEALTH AND WELLBEING BOARD

Care Quality Commission Looked After Children and Safeguarding Review

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1. Purpose of Report

1.1 This report is to inform the Health and Wellbeing Board with about the announced Care Quality Commission (CQC) review of services for Looked After Children (LAC) and Safeguarding in Barnsley.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the information provided and the implications for Board members as providers/commissioners of children's services.

3. Introduction/ Background

3.1 The Care Quality Commission (CQC) are undertaking a review of services for Looked After Children (LAC) and Safeguarding on a national basis.

3.2 Barnsley CCG were notified on Thursday 13th November 2014 by the CQC that they planned to conduct a review of services for LAC and Safeguarding in Barnsley commencing Monday 17th November for a week, ending on Friday 21st November.

3.3 The inspectors provided an indicative timetable for the areas they wished to visit and the staff groups they wanted to meet. They also requested summaries of case files so they could track a child's journey through the health system.

3.4 Prior to their arrival on site they reviewed relevant child health performance reports and data relating to NHS commissioning and provider activity which are in the public domain. They also requested key documents that are not available publically for example action plans of Serious Case Reviews, progress reports to Safeguarding Board/Trust Boards in relation to recommendations for health from previous inspections, recent reports outlining GP performance in relation to Safeguarding and LAC. The key lines of enquiry for the review were informed by

the new policy Direction for Vulnerable Children and CQC's priorities and they support a new framework and reporting arrangements centred on:

- The experiences and views of children and their families.
- The quality and effectiveness of safeguarding arrangements in health including:
    - Assessing need and providing early help.
    - Identifying and supporting children in need.
    - The quality and impact of child protection arrangements.
- The quality of health services and outcomes for children who are looked after and care leavers.
- Health leadership and assurance of local safeguarding and looked after children arrangements including:
    - Leadership and management.
    - Governance.
    - Training and supervision

4. Key Findings

4.1 At the end of the inspection feedback was given to key representatives from all health agencies including BMBC Children and Families Directorate. There will be no grading on the final report however there will be suggested recommendations for improvement. The inspectors found nothing of concern throughout the week that required immediate remediation. They reported that they judged that the CCG had good leadership in place.

4.2 **Emergency Department and New Street Clinic**

4.2.1 The inspectors visited the Emergency Department at Barnsley Hospital NHS Foundation Trust (BHNFT) and spoke to the Doctors at New Street clinic who undertake LAC Initial Health Assessments and they also spoke to the Named Nurse for LAC who is employed by South West Yorkshire Partnership Foundation Trust (SWYPFT). The team reviewed case files of Barnsley LAC living in Barnsley and those placed out of the area.

4.2.2 Initial feedback from the inspectors was that they found some good examples of professional curiosity and tenacity from staff in the Emergency Department in relation to ensuring good outcomes for children about whom they had safeguarding concerns.

4.2.3 The inspectors stated that the LAC assessments were timely, however they felt that commissioners and Corporate Parents should have more awareness as to how many LAC are awaiting Child and Adolescent Mental Health Services (CAMHS) appointments. They identified that there is no dedicated CAMHS service for LAC and said that the waiting times were unacceptable as for some children it was taking approximately one year before the first appointment is allocated.

4.2.4 The ethnicity of children and young people although recorded by Emergency Department reception staff at the time of registration was not being printed on the Emergency Department Casualty card. This means that practitioners treating the child or young person may not be aware of any cultural sensitivities in relation to the young person or their family.

4.3 **Key findings – Maternity Services at BHNFT, CAMHS and Adult Mental Health Services at South West Yorkshire Partnership FT**

4.3.1 Inspectors found some excellent examples of good practice in Midwifery with good referrals to Social Care. The inspectors saw an example of the use of the Mental Capacity Act and Deprivation of Liberty Standards and said the record keeping was excellent in the case reviewed.

4.3.2 Midwives have been collecting information for planning the care of expectant mothers. In the cases examined the inspectors found that the information process did not aid person centred care and was not SMART. The use of the ante-natal clinic care plan did not aid recording of planned outcomes with clearly defined timescales for actions to be completed – this was seen as a missed opportunity.

4.3.3 Most health professionals from the above services told the inspector that timeliness of responses by Local Authority Safeguarding teams to referrals being made was generally good and there was at least 10 days notification of safeguarding issues. However School Nurses stated that this varied according to the area.

4.3.4 The perinatal mental health pathway for women in Barnsley to access specialist support is not compliant with the National Institute of Clinical Excellence (NICE) guidance, but providers are working closely with commissioners to develop more robust care pathways.

4.3.5 The inspectors found that CAMHS safeguarding supervision is not routinely recorded and that there is no composite CAMHS record, the information is held on 2 separate databases and also in paper records.

4.3.6 The inspectors felt that the availability of CAMHS services to support children and young people's emotional health and wellbeing at Tier 2 is limited; this will be addressed via the health and Wellbeing work that the CCG are leading on.

4.3.7 CAMHS practitioners demonstrated good commitment to their service users and worked hard to keep children, young people and families engaged. The inspectors saw evidence of robust and targeted risk assessments that resulted in good care planning and high quality safety plans to help protect vulnerable young people.

4.3.8 CAMHS practitioners were identified as using Datix Incident Reporting process to record when a referral to children's Social Care has been made. These referrals are not routinely copied to The SWYPFT Safeguarding Team.

The inspection found there is no complete client record held by CAMHS and record documents are not scanned into RIO the IT system, used by South West Partnership Foundation Trust (SWYPFT). The Inspectors stated that this is not safe practice. Since the Inspection an updated Datix system has been implemented to address these issues.

4.3.9 In all cases there was evidence of Adult Mental Health practitioners working collaboratively across the partnerships e.g. children's social care, midwifery etc.

4.4 **Key findings - School Nursing Service, Contraception and Sexual Health Service (CASH), Health Visiting Service and Adult Substance Misuse service**

4.4.1 The School Nurses were found to have made good contacts with Faith Schools in Barnsley; practitioners expressed concerns to the inspectors regarding paper records/SystmOne and issues regarding Dentists and information sharing. The Designated Nurse has now resolved the issue of information sharing by Dental Practices, and requested early escalation of anything similar.

4.4.2 CASH were found to have some good examples of the use of chronologies within records, excellent referrals to Social Care and use of the risk assessment on the IT system. The Inspectors felt that there was good assessment for stage 3 child sexual exploitation cases, however concern was expressed as they had held on to a case longer than they should have as the safeguarding lead was off site (however there was a good outcome for the child overall).

4.4.3 In Adult Substance Misuse it was reflected that there was good recording of when children are present in the household. Inspectors felt that planning could be smarter but workers did consider the impact of the substance misuse on the child.

4.4.4 There were no concerns raised regarding the role of the Health Visiting service in relation to LAC. They have benefited from the Barnsley Safeguarding Children Board Thresholds document which was felt to have enabled more robust referrals to Social Care and smooth transfers of children from Health Visitors to the School Nursing service.

4.5 **Key findings – Primary Care GP's and LAC Health Assessments**

4.5.1 The inspectors visited several GP practices and reviewed children's case notes. The inspectors also had contact with service users and parents to get their feedback on the services they had received.

4.5.2 The findings were that GP's are not routinely invited to contribute to the Initial Health or Review Health Assessments for LAC and if they were this was not

clearly recorded. They highlighted that there was no evidence of GP information being provided and used to inform the decision process.

4.5.3 It was also identified that LAC Health Assessments are not routinely scanned onto GP records (the Named Doctor and Designated Nurse have advised all practices, as part of the GP Safeguarding Stock take, that Child Protection Conference Reports and LAC reviews should be scanned onto the child's record to ensure that they have a complete record of the child's health).

4.5.4 The Inspectors were impressed by the electronic report for Child Protection Conference developed by the Designated Nurse and Named Doctor but they felt that GP's were not widely using the report.

4.6 **Final Feedback**

4.6.1 The inspectors said the report of their findings may take six weeks before it is sent to the CCG which will enable a factual accuracy check to be made. The time delay is because of the Governance and Quality assurance processes that the CQC have in place. Therefore the CCG expected to receive the report in January 2015, the report has not been received to date.

5. Conclusion/ Next Steps

5.1 This inspection reflects the findings of the recent Ofsted Inspection of BMBC Safeguarding Children and LAC services that Barnsley "know its self" as a result of excellent partnership working. We are aware of our strengths and we know where we have areas that require improvement.

5.2 There is a Multi-agency Service Improvement plan in place which will address any issues identified by the CQC. This is monitored monthly by the Improvement Group which has representation from Health Providers and the CCG.

5.3 Local authorities, NHS England and CCGs must cooperate to Commission health services for children in their area and as a partner agency of the BSCB the CCG has a role to ensure that we are part of the robust assurance process, through effective interagency challenge, to ensure that children and young people's safety and welfare is paramount and maximised in Barnsley. The CCG also has a duty to cooperate with local authorities to undertake health assessments and help them provide support and services to LAC.