NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group Governing Body Meeting

Date: Tuesday 3rd April 2018

Time: 1.30pm

Location: Vassall Centre, Gill Avenue, Downend, BS16 2QQ

Agenda item: 8.2

Report title: Briefing on the Bristol Serious Case Review 'Becky' and the implications for the CCG

Report Author:

Report Sponsor:

1. Purpose

To provide the Governing Body with a briefing on the recently published Serious Case Review (SCR) which explores the learning for all agencies involved in the care of Becky Watts. This briefing will focus on the specific learning for the CCG as the commissioner for the health services who provided support to Becky and her family. The SCR is a focus on Becky, her life and her experiences.

2. Recommendations

The Governing Body is asked to receive this update on the 'Becky' Serious Case Review and to review, comment on and approve the CCG action plan in Appendix 1. The Governing Body is asked to delegate the monitoring of the action plan to the BNSSG CCG Safeguarding Governance Group and the Quality Committee with oversight from the Director of Nursing and Quality as Executive Lead for Safeguarding. The Quality Committee will receive any exception reports if the action plan is not progressing as planned.

3. Background

Working Together to Safeguard Children 2015 states that it is mandatory to carry out a SCR when a child dies or is murdered and abuse or neglect are known or suspected. Becky was

reported missing on 20 February 2015 and her body was found on 3 March 2015. Becky's step-brother was found guilty of the murder of Becky and his partner was found guilty of manslaughter. Both are serving custodial sentences of 33 and 17 years respectively.

The SCR was carried out by 2 lead reviewers using the Social Care Institute of Excellence (SCIE) systems methodology between September 2015 and September 2016. The publication of the report has been delayed due to the recommendation of the review panel to the Bristol Safeguarding Children Board (BSCB) that a Domestic Homicide Review (DHR) be undertaken given the circumstances of Becky's death. This was referred to the Safer Bristol Partnership Board who agreed with this recommendation and this led to delays in the SCR being completed.

The SCR review panel comprised of senior representatives from local agencies, including the Named GP for Safeguarding Children in Bristol and the Deputy Designated Nurse in Bristol. The report covers a three and a half year period between 2012 and Becky's death in March 2015. The report is 32 pages long and has identified 5 key findings highlighted below:

1. Services need to be focussed on an evidence based understanding of the needs and circumstance of adolescents; the absence of this can lead to adolescents inappropriately becoming the focus of concern and being seen as 'troublesome' rather than 'troubled' because of their circumstances.
2. The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.
3. Children in receipt of specialist services from Hospital Education Services (HES) have complex needs and some require a multi-agency response to meet these needs. Despite this HES are often working alone in providing services to children; such lone working does not meet the needs of all children.
4. The propensity for professionals to take parent/carer perspectives at face value without triangulating information from other sources, including observations of how a child or young person appears, can lead to a limited understanding of a child or young person's needs.
5. Professionals are less challenging of the lack of engagement of fathers in child welfare practice leaving the risks they may pose unassessed and the contribution they could make to children's lives unknown.

Findings 2 and 3 have specific implications for health services. All agencies have a duty to review all the findings and ensure they have addressed any learning needs they have identified. The full report and the press briefings related to this case can be accessed on the Bristol Safeguarding Children Boards Website link below:

https://bristolsafeguarding.org/children-home/news/becky-serious-case-review/

4. Findings from the SCR that are specific to the CCG and its commissioning of health services

Below are the 2 findings specific to health from the 5 findings listed above. The table below provides some context on the current progress position on these actions.

	Findings	Implications for health

2	The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.	**There are implications for CAMHS in this finding.** **There was no IT system and hand written records were difficult to read. Letters were shared with GP and partners but they were extensive and lost some of the focus in the narrative.** **The New CAMHS provider (AWP) under the new CCHP contract have now implemented electronic records, these are being rolled out across their workforce.** **This will improve legibility of records, retrieval and improve supervision and oversight by Managers and the Safeguarding Team.**
3	Children in receipt of specialist services from Hospital Education Services (HES) have complex needs and some require a multi-agency response to meet these needs. Despite this HES are often working alone in providing services to children; such lone working does not meet the needs of all children.	**The reports indicate other services should be available to support HES when they are working with young people.** **Staff need to recognise that CAMHS and other services work on targeted work and do not hold universal responsibility. They offered a consultation and advice service but this was not understood by the HES service.** **The new provider of CAMHS have allocated a primary mental health worker to link with HES** **The Local Authority Public Health Team who commission School Nursing will review what support they commission for this service.** **GPs are a universal services but in this case had limited contact with Becky.**

5. Learning points from this SCR specific for the CCG

The SCR recognise that professionals come to work with the intention to do their best for the child and the families they work with. Sometimes the systems in place do not always make this easy. It is equally important to learn what was working well so good practice can be replicated and shared. In this SCR there were some areas of good practice within the CAMHS service these included:

- Seeing the family within 4 weeks of referral,
- One of the teams worked with the wider family which moved their thinking to recognising that the early childhood trauma Becky experienced impacted on her current situation,
- There was effective work to manage Becky's eating disorder and the communication and support from the GP.

However there were still learning points which must be addressed and these are highlighted below:

- There were 3 CAMHS Teams (Psychology, Family Therapy and Eating Disorder Teams) involved with Becky and her family providing different services. There was no process to consistently share their assessments and each team worked in isolation. (Finding 2)

- The report highlights there was an overall acceptance across all agencies that 'Becky' was 'troublesome'. In the CAMHS family therapy sessions this thinking was revised to recognise that Becky was reacting to her life experiences and early childhood trauma. Unfortunately this new thinking was not shared with other agencies working with Becky and therefore did not impact on any future assessments. (Finding 2)

- Becky was seen promptly by the CAMHS service for her eating disorder. She was referred and accessed a community service supported by the GP. With this level of supported care in the community, she made positive progress. This was a 13 month treatment plan and the wider family were reviewed and assessed again by CAMHS. This assessment was not linked to the other family therapy assessment because there were only hand written records and these were not linked to wider CAMHS services. Within CAMHS there was no process to have one set of records for any one client. The GP received summary reports of all these services, so would have had the whole picture but was not included in any multi-disciplinary or agency meetings. The newly commissioned CAMHS Service now has an electronic system (IAPTUS). The intention of this IT system is to link the consultations from all CAMHS contact into one set of records. This system does not currently link to Connecting Care and it is not linked to the RIO IT system for adult mental health services (Finding 2).

- When CAMHS ended their treatment plan they offered an open access consultation service to the Hospital Education Service (HES) for Becky. Unfortunately the HES thought they had to make a new referral for CAMHS through the GP. This meant they did not seek any further advice or support on managing Becky and her emotional health. Communication could have been improved if the HES had received a letter explaining what help and support they could expect and how they could access it. Since this SCR the new provider for CAMHS now has a primary mental health worker allocated to the HES service. (Finding 3).

6. Financial/resource implications

If there is a review of any IT system and how this links to Connecting Care and other mental health systems, this would have an implication on financial resources.

7. Legal implications

There are no legal implication identified in this report for the CCG

8. Risks/mitigations

IT Infrastructure

The current IT system used by CAMHS is IAPTUS. This is a system used by Talking Therapies commissioned by Bristol CCG. This System does not link to the Connecting Care system so any information from CAMHS would not be visible to any service outside

CAMHS including Avon and Wiltshire Mental Health Partnership (AWP) who commission CAMHS.

It is a positive move that CAMHS now have electronic records but it was a missed opportunity that they did not use the RIO system used by adult mental health services. RIO already has a process to share information through Connecting Care. With CAMHS work being recorded on IAPTUS this may also cause problems if young people transition into adult mental health services. The provider will need to ensure they have an effective mechanism to summarise and support any transition of care.

9. Implications for health inequalities

None identified.

10. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

None Identified

11. Consultation and Communication including Public Involvement

This SCR was published on 15 March 2018. The Bristol Safeguarding Children Board commissioned the SCR and led the press conference. There were representatives from the CCG and AWP as the current commissioner of CAMHS as well as Social Care and the Police. The Press only had health questions for the CAMHS representative, and these related to Becky's mental health. There were no questions about the health care she received or the support offered to the wider family.

Most of the press coverage focused on the issues of sexual exploitation as this was raised in the report when Becky had sent a revealing photo to a boyfriend who was threating to share the photo more widely. There was no organised exploitation identified. The press also focused on why the step brother was not a stronger focus in the report. As mentioned above the SCR is the opportunity to hear Becky's voice and story and to identify what learning we have for her care. The wider picture of the perpetrator is covered in the DHR process.

12. Appendices

1. **CCG Action plan on the learning from the 'Becky' SCR**
2. **The BSCB action Plan for multi-agency learning on the 'Becky' SCR**
3. **The BSCB SCR 'Becky.**

Jacalyn Mathers
Head of Safeguarding Children (Designated Nurse)
21.03.18

Anne Morris
Director of Nursing and Quality
Executive lead for safeguarding BNSSG
21.03.18

Glossary of Terms and Abbreviations

Please explain all initials, technical terms and abbreviations. For guidance please refer to the Jargon Buster and the CCG's Master Glossary – both are available on the website.

SCR	**Serious Case Review**
DHR	**Domestic Homicide Review**
CAMHS	Child Adolescent Mental Health services. This service is part of the
IAPTUS	The 'leading patient management software for Psychological therapies. Avon and Wiltshire https://iaptus.co.uk/
AWP	Avon and Wiltshire Mental Health Partnership Trust
RIO	RIO is an electronic patient record system used by many providers especially community and mental health trusts. It is enabled to link with eth Connecting Care system across BNSSG. https://www.digitalhealth.net/2008/12/its-name-is-rio/
Connecting Care	Connecting Care is a digital care record system for sharing information in Bristol, North Somerset and South Gloucestershire. It allows instant, secure access to your health and social care records for the professionals involved in your care. Relevant information from your digital records is shared with people who look after you. This gives them up-to-date information making your care safer and more efficient https://www.connectingcarebnssg.co.uk/
PMHS	Primary Mental Health Specialist who work with children aged 5-18 years and their carers supporting their mental health and emotional well being http://cchp.nhs.uk/cchp/explore-cchp/child-family-consultation-services-camhs/primary-mental-health-specialists
CCHP	Community Child Health Partnership Community Children's Health Partnership (CCHP) Services are provided by Sirona care & health CIC working closely with our partners Bristol Community Health CIC, Avon and Wiltshire Mental Health Partnership NHS Trust, University Hospital Bristol NHS Foundation Trust, Barnardo's and Off the Record. Together we provide all of the community child health and child and adolescent mental health services for Bristol and South Gloucestershire. http://cchp.nhs.uk/
SCIE	Social Care Institute of Excellence (SCIE) systems methodology.

	Is a particular process for undertaking learning reviews it is based on the health system of Route Cause Analysis but has been developed by Social care and a model of reviewing SCR. This has been flagged as a preferred model by Eileen Munro in her report to the Government on managing Child protection systems for social care. It has a basis of working on research questions and not from Terms of Reference. https://www.scie.org.uk/publications/ataglance/ataglance01.asp
Healthy child program 0-19 commissioning for Health Visiting and School nursing	The guidance has been republished to reflect new evidence and guidance to support local authorities commissioning 'public health services for children and young people' and in particular delivering the healthy child programme 0 to 5 and 5 to 19. It focuses on the contribution of health visiting and school nursing services leading and coordinating the delivery of public health for children aged 0 to 19. The healthy child programme aims to bring together health, education and other main partners to deliver an effective programme for prevention and support. https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning
BSCB	Bristol safeguarding Children Board
HES	Hospital Education Service The Hospital Education Service is for pupils who miss school because of severe or chronic ill health, including serious mental health. The service also helps students who frequently need hospital treatment followed by periods at home or in school. Pupils are referred to us by health professionals. http://www.bristolhes.co.uk/

APPENDIX 1

CCG action plan on the learning from the 'Becky' SCR

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

The DRAFT CCG action plan in response to the BSCB Becky SCR

Action required	lead	Complete date	Evaluation/ impact on the child	Progress to date	RAG
AWP as the current provider of the CAMHS service should provide the commissioners with a report on how they respond to the learning and the 5 finding from the 'Becky' SCR and what action plan they have put in place.	Safeguarding team	4 May 2018	CAMHS will demonstrate their own learning form this SCR evidencing the impact any learning will have on children and families accessing their service	This is an issue which is addressed in safeguarding supervision and training. The 'Think Family' approach is being embedded into practice and practitioners are being encouraged to build their confidence through training to challenge fathers' non-engagement in working with children and young people.	Partially complete.
For the provider to give the CCG assurance that the new IAPTUS electronic record system links all CAMHS records so a child will only have one set of records.	CAMHS Commissioner	4 May 2018	Ensure children are not be seen in isolation to the therapies they receive	The IAPTUS electronic recording system is now in place across CAMHS. In-patient mental health services use a different electronic system but there is a shared place for discharge information to which senior clinicians and safeguarding practitioners have access. Planned retrospective auditing of records will ensure that analysis of all information is undertaken.	Partially complete.
CAMHS need to provide evidence they are effectively communicating with all key partners who are working with the child and family they are treating. The communication should be	CAMHS commissioner	31 May 2018	Children and families do not have to relay information between professionals and continuity of care will be in place.	The Signs of Safety (SOS) model of practice is being embedded across all agencies for Single Assessment Frameworks (SAFs) in the partnership	Partially complete.

Action required	lead	Complete date	Evaluation/ impact on the child	Progress to date	RAG
concise, appropriate and with a suitable summary.				which will enable better coordination of care under a lead practitioner.	
CAMHS need to provide the CCG with assurance when families are receiving multiple therapies there is effective coordination of their care and one practitioner is identified as a lead for their care.	CAMHS Commissioners	31 May 2018	The child and family will have one point of contact who will liaise on their behalf	Lead practitioner training has been requested by health agencies from the BSCB as this role is currently only undertaken by social care professionals.	Incomplete.
The CCG need to seek assurance through the CCHP contract that there is sufficient school health nursing support for the Hospital Education Service (HES)	LA Children's Commissioner responsible for CCHP	May 2018	Children who have identified health needs receive appropriate access to school nursing advice and support.	For 5 - 19's the healthy child programme is adapted to suit local need and capacity, but all young people, schools and other institutions who serve children and young people in this age group will have access to signposting advice.	Partially complete.
Health practitioners need to ensure that they do not take parent / carer perspectives at face value without triangulating information from other sources. Ensuring that the voice of the child / young person is heard.				Health staff are made aware of the importance of the voice of the child or young person through training alongside the importance of speaking to the child or young person alone to ascertain their views and perspectives which may require time to build the young person's confidence in the professional. There is evidence from primary care that practitioners make certain that they see young people alone so that they can	Partially complete.

Action required	lead	Complete date	Evaluation/ impact on the child	Progress to date	RAG
				be clear that they understand the issues from the young person's point of view.	

APPENDIX 2

The BSCB action plan for multi-agency learning on the 'Becky' SCR
Attached as a e pdf

APPENDIX 3

The BSCB SCR 'Becky.

Link to the BSCB
https://bristolsafeguarding.org/children-home/serious-case-reviews/bristol-scrs/becky-2018/

BECKY DRAFT ACTION PLAN

Last update: 01/03/18 % complete: 36%

Taken from review			Developed by Board				Progress monitoring	
No.	**Finding**	**Recommendation**	**Action**	**Lead**	**Complete by**	**Evaluation**	**Update (include date)**	**RAG**
1	Services need to be focussed on an evidence based understanding of the needs and circumstance of adolescents; the absence of this can lead to adolescents inappropriately becoming the focus of concern, and being seen as “troublesome” rather than troubled because of their circumstances.	Are services appropriately structured in order that evidence-based approaches can be provided for adolescents that agencies find hard to engage?	Transformation of Children's Services to provide a more integrated offer across Level 2 and Level 3 services including the implementation of the EIP2 Signs of Safety Innovation Project involving all partners across the city adopting the same methodology when working with families	CFPB	Jul-18	Review Becky's case as a case study against the new integrated localities model	Model presented to the Board in Feb 2018. Will be implemented in April 2018	outstanding
1		How can BSCB support professionals to feel equipped and confident to carry out this complex work?	Increase offer for Safeguarding Adolescent course in 2018-2019	Training Sub Group	Apr-18	3month training impact and qualitative discussion with Shadow Board about experiences of their participation groups		outstanding
1			BSCB to run a conference on adolescent identity and support needs	Training Sub Group	Jul-17	Conference impact questionnaire		Complete
1			CASCADE Training rolled out to safeguarding leads in Bristol schools	Education Sub	Mar-17			Complete
1			BCC Implementation of Adverse Childhood Experiences Teams	BCC SCR rep	Jun-18			outstanding
1			BSCB to support Avon and Somerset Campaign on CSE and adolescent vulnerability		Mar-18	Increased number of children identified at risk of CSE	Campaign supported in 2016 and 2017. March 2018 campaign for CSE Awareness week	Partially Complete
1		What can BSCB learn from the work of voluntary sector agencies about dealing effectively with disclosures?	Commission sexual violence services training on CSA	Training Sub Group	Mar-18	Impact report from training to show increase in confidence from attendees	Training delivered by the Southmead project	Complete
1			BSCB to promote the Bristol Survivor Pathway through the website	Comms Sub Group	Mar-18	Increased number of referrals to SV services	Services have seen a significant increase in referrals over the last year - not just from the Survivor Pathway promotion but wider context	Complete

No.	Finding	Recommendation	Action	Lead	Complete by	Evaluation	Update (include date)	RAG
1			All core BSCB training programmes to include management of disclosure in line	BSCB Training	Mar-18	Impact report from training to show increase in confidence at safeguarding children from attendees	Training has been reviewed and covers this issue	Complete
1		How will BSCB be informed of changes achieved through the learning and development in this area?	Data scorecard to be developed to measure key outcomes for adolescents including aiming for a reduction in care entries for adolescents	BSCB Data Analyst	Apr-18	Increase in Boys identified as victims of CSE, reduction in adolescent care entrants		outstanding
2	The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.	Is the Board confident that record keeping is suitably robust in each agency and the function of record keeping is clearly understood by across all agencies?	Record keeping including the use of paper or online systems to be audited across the Board as part of the Section 11 audit	BSCB Policy Officer	Aug-18	Section 11 submissions and increased conversation rate of contacts to referrals to First Response		outstanding
2			CAMHS and education to introduce improved electronic record keeping	Health and Education Sub Groups	Dec-17	systems in place across the service		Complete
2			Implementation of Connecting Care	Health Sub Group	Dec-17	Overseen through JTAI action plan		Complete
2		What current mechanisms are in place to ensure that complex, multi-factorial risks and needs are effectively assessed and reviewed within non-statutory multi-agency interventions?	Transformation of Children's Services to provide a more integrated offer including across Level 2 services. This to include review of Lead Professional role and assessment of need at Level 2 services as part of the EIP2 Signs of Safety Innovation Project	CFPB	Jul-18	Improved outcome measures. Measures TBC		outstanding
2			Introduction of the NSPCC G|CP2 neglect tool	JTAI working group	May-18	Increase in numbers of adolescent where neglect is identified	Agreed by BSCB on feb 2018 Board. Train the Trainer April 2018	Partially Complete
2		How will the Board ensure that new multi-agency and multi-disciplinary developments are informed by this finding?	SCR to be widely disseminated to commissioners and strategic leads as part of comms plan for publication	BSCB Chair	Mar-18	Number of downloads of SCR		outstanding

No.	Finding	Recommendation	Action	Lead	Complete by	Evaluation	Update (include date)	RAG
3	Children in receipt of specialist services from Hospital education services (HES) have complex needs, and some require a multi-agency response to meet these needs. Despite this, HES are often working alone in providing services to children; such lone working does not meet the needs of all children.	How can the Board facilitate the development of a partnership and accessible pathway between specialist services and other services that improves the coordinated multi-agency, multi-disciplinary response to a specifically vulnerable group of children?	Transformation of Children's Services to provide a more integrated offer across Level 2 and Level 3 services including the implementation of the EIP2 Signs of Safety Innovation Project involving all partners across the city adopting the same methodology when working with families	CFPB	Jul-18	Review Becky's case as a case study against the new integrated localities model to understand effectiveness for children in alternative education provision		outstanding
3			Commissioning action here					outstanding
3		How can the Board support specialist services such as HES in undertaking the role of Lead Professional in cases at this threshold?	Develop Lead professionals role and framework as part of new model of integrated localities - BSCB to provide training	BCC SCR rep				outstanding
4	The propensity for professionals to take parent/carer perspectives at face value without triangulating information from other sources, including observations of a how a child or young person appears, can lead to a limited understanding of a child or young person's needs.	How will the Board ensure that partner agencies provide the tools, reflective supervision and culture which help professionals to remain in a position of "respectful uncertainty" and display "healthy scepticism"?	Targeted self-audit questions on use of guidance as part of implementation review	BSCB Policy Officer	Jun-18	Qualitative data highlighting appropriate use of reflective supervision		outstanding
4		Is the Board assured that multiple hypotheses are used to explore and better understand complex family dynamics and is evidenced in recordings?	Implementation and extension of the Signs of Safety model	SoS working group	Dec-17	Ongoing case audits by the QP sub group		Complete
4			Transformation of Children's Services to provide a more integrated offer across Level 2 and Level 3 services including the implementation of the EIP2 Signs of Safety Innovation Project involving all partners across the city adopting the same methodology when working with families. This model will allow consultation and oversight of cases by a locality meeting.	CFPB	Jul-18			outstanding
4		Do Board partners have information systems and information sharing arrangements in place which adequately facilitate accurate triangulation of information?	Implementation of Connecting Care	Health Sub Group	Dec-17	Overseen through JTAI action plan		Complete

No.	Finding	Recommendation	Action	Lead	Complete by	Evaluation	Update (include date)	RAG
4			Report to the Board on the attendance of partners at Child Protection Conferences	Conference Service	Jul-18	Increased attendance of professionals		outstanding
4			Implementation of Missing and DV notification processes in education settings	Education Sub	Sep-17	Pilot evaluation report to Board in Feb 2018		Complete
4		Are professionals encouraged to pose and consider reflective questioning within multi-agency discussion in order to improve assessments and understanding of family functioning over a period of intervention?	Audit of assessments across the partnership	QP Sub Group	Sep-18	Evidence of considered family functioning within assessments		outstanding
5	Professionals are less challenging of the lack of engagement of Fathers in child welfare practice leaving the risks they may pose unassessed and the contribution they could make to children's lives unknown.	Can the Board be assured that the Think Family approach to considering all family members has been fully embedded within frontline practice?	See action for Finding 4 re audit of SoS and action for Finding 1 re involvement in EIP. Compliance with this model will requires professionals to do Genograms and speak to all people in a child's network.	CFPB	Jul-18			outstanding
5			Board Chair to highlight risk of commissioners not being able to offer out of hours services which better engage fathers through the use of the Board risk register and challenge to Health and Wellbeing board	Board Chair			Escalated to HWB in Feb 2018	Partially Complete