

# **Review of health services for Children Looked After and Safeguarding in West Sussex**

# Children Looked After and Safeguarding

## The role of health services in West Sussex

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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in West Sussex. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than West Sussex, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 71 children and young people.

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## Context of the review

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Most of West Sussex residents, 57.6% (485,090 residents) are registered with GP practices that are part of the NHS Coastal West Sussex Clinical Commissioning Group (CCG). There are 214,738 West Sussex residents (25.5%) that are registered with a GP practice that is part of NHS Horsham and Mid Sussex CCG and there are 117,773 residents (14.0%) that are registered with a GP practice that is part of NHS Crawley CCG. There are some West Sussex residents that are registered with GPs that are a part of further CCGs but these are much lower in number.

The current 2014 West Sussex Child and Maternal Health Observatory (Chi Mat) profile identifies that children and young people make up 22.5 % of West Sussex population with 14.7 % of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in West Sussex is generally better than the England average. The infant and child mortality rates are similar to the England rates.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly lower than the England average. This also corresponds with West Sussex having a significantly higher percentage of looked after children having up to date immunisations when compared to the England average.

Chi Mat reports that in 2013, the overall percentage of all West Sussex children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared against the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2011/12, was significantly better when compared to the England average rate. The rate of hospital admissions caused by injuries for children under 14 years of age was not significantly different when compared to the England average. However, the rate of hospital admissions caused by injuries for young people between the age of 15 and 24 years was significantly worse when compared to the England average.

The rate of hospital admissions for mental health conditions was significantly better than the England average in 2012/13. The rate of hospital admissions as a result of self-harm in same time period however was significantly worse than that the England average.

In 2011, the conception rate for under 18 year olds per 1000 females was significantly better to the England average. This corresponded with the significantly lower percentage of teenage mothers in 2012/13 when compared to the English average.

In 2014, the DfE reported that West Sussex had 420 looked after children that had been continuously looked after for at least 12 months as at 31st March 2014, excluding those children in respite care. The DfE reported that 95.2% (400) of these children received their annual health assessments. This percentage is greater than the England average of 88.4%. The percentage of looked after children that had their teeth checked by a dentist in West Sussex was 92.9% (390), which is higher than the England average of 84.4%. As at 31<sup>st</sup> March 2014, there were 45 looked after children who were aged five or younger, the DfE reported that all of these looked after children had up to date development assessments.

Commissioning and planning of most health services for children are carried out by NHS Coastal West Sussex CCG, NHS Crawley & NHS Horsham and Mid Sussex Clinical Commissioning Groups.

Commissioning arrangements for looked-after children's health are the responsibility of NHS Coastal West Sussex CCG on behalf of NHS Crawley & NHS Horsham and Mid Sussex Clinical Commissioning Groups and the looked-after children's health team, designated roles and operational looked-after children's nurses, are provided by Sussex Community NHS Trust.

Acute hospital services (including maternity services) are provided by Western Sussex Hospitals NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals Trust.

Health visitor services are commissioned by the CCGs and provided by Sussex Community NHS Trust.

School nurse services are commissioned by West Sussex County Council and provided by Sussex Community NHS Trust.

Contraception and sexual health services (CASH) are commissioned by West Sussex County Council and provided by Western Sussex Hospitals NHS Foundation Trust.

Child substance misuse services are commissioned by West Sussex County Council and provided by CRI.

Adult substance misuse services are commissioned by West Sussex County Council and provided by CRI

Child and Adolescent Mental Health Services (CAMHS) are provided by Sussex Partnership Foundation Trust and the CAHMS LAAC service is commissioned by West Sussex County Council

Specialist facilities are provided by Sussex Partnership Foundation Trust

Adult mental health services are provided by Sussex Partnership Foundation Trust

The West Sussex integrated inspection of Safeguarding and Looked after Children's Services took place in November 2010. Recommendations from that review will be covered in this report.

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## The report

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This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

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## What people told us

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We heard from children in care and care leavers:

*“My health check was really fine. She weighed and measured me. I got to pick the time and place and the nurse came to my house, I filled in a form that said I gave consent which I thought was good. I was seen on my own too, not with my (foster) mum and that was good.”*

*“It was the first time I had met the nurse. She was friendly and open and easy to talk to, so I felt I could ask her questions.”*

*“I got a copy of the assessment afterwards and was able to fill in a feedback questionnaire about how the health check went and it went into a sealed envelope”*

*“I had a choice about where the health review happened. I preferred to have it at home as I didn’t want everyone knowing I was going out of school to meet the nurse.”*

*“She (the looked-after child nurse) was really nice. Bubbly and nice. Very easy to talk to. We did this game when I first met her, with cards. It was so funny”*

*“Since meeting the nurse and seeing her for a few times afterwards I have really changed. I would love to see her again. She has made such an impression on me. She told me all about safe sex and relationships and safety. I have a much healthier new relationship with a new boyfriend and I am much happier about things. She changed my life.”*

We heard positive feedback from parents we spoke to in East Surrey Hospital ED about the treatment they and their children received.

*“You get a great service here for children. The staff are very approachable and we are always very happy with the treatment our children get here. Keep up the good work! They have been really good with our son.”*

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## The child's journey

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This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

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### 1. Early help

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1.1 Young expectant and new parents are well supported across West Sussex with access to the young parents group at health and family centres and peer support initiatives via social media. The Family Nurse Partnership is well established however the service is currently commissioned to meet the needs of only approximately 20% of young mothers who fulfil the criteria for the programme.

1.2 The early parenting group, weekly drop in sleep support clinic and post natal depression group, in conjunction with local MIND services, are recently established initiatives in some parts of West Sussex. Although it is too soon to see the impact of this on outcomes, the groups have been well received by new parents as a means to access advice and support on a regular basis from the health visiting teams.

1.3 Arrangements for expectant mothers with additional needs are variable across West Sussex. At East Surrey Hospital (ESH) and Western Sussex Hospitals there are no specialist services, aside from the counselling midwife and safeguarding midwife. However at Princess Royal Hospital (PRH), there is a "one stop" midwife who is part of a dedicated clinic involving a social worker and specialist nurse for substance misuse which specifically supports expectant mothers with substance misuse issues or that are homeless. Across all sites there is limited commissioned support available for mothers in the ante and post natal period with mental health issues and this is a gap. (**Recommendations 1.2, 4.2, 5.3**)

1.4 Arrangements for expectant mothers with low and moderate substance misuse are under developed. Drug and alcohol misuse commissioning arrangements do not address the special needs for supporting women who are pregnant, especially those with low level substance misuse. Practitioners we met with reported a lack of clarity about how to access support in these cases. ***This information will be brought to the attention of Public Health England.***



1.5 Flexible maternity booking arrangements are in place to ensure newly expectant mothers have easy access to health advice. These are available online, via GP surgeries and at over 100 clinic sessions held at children's centres, GPs or hospitals. The parent craft offer at ESH includes specialist sessions for the local Polish community alongside evening and weekend sessions to ensure everyone can easily access this valuable support. There is also a liaison midwife who links with the detention centre at Gatwick airport to ensure that expectant mothers arriving into the country can access health services. At PRH, specialist individualised sessions are available to support teenage parents and include support to visit the hospital and birthing unit, and help with transport to appointments to facilitate attendance.

1.6 Some cases we reviewed highlighted a lack of individualised birth plans being held on records. This was particularly at PRH where the ante-natal care is likely to be provided by community midwifery from a different health trust. There is more to do to ensure seamless planning and transition of care in the ante-natal and immediate post natal period for expectant mothers, especially those who are accessing various health organisations in the different phases of pregnancy, to ensure their needs are fully met. (**Recommendation 5.1**)

1.7 Following recent training at the midwifery study day, midwives at ESH have a heightened awareness of female genital mutilation (FGM) and are now routinely discussing this at the booking appointment. This ensures women who are victims are identified for support at the earliest opportunity.

1.8 Midwives across all sites we visited demonstrated good awareness of domestic violence (DV). At ESH, DV questions are routinely asked at booking and again at 28 weeks, and women are provided with opportunities to see the midwife alone. At Worthing, the teenage pregnancy midwives maintain their own separate record of DV questioning and responses, outside the hand held notes and these questions are repeatedly reviewed with the young person.

1.9 Multi-disciplinary "early help" and "special issues" midwifery liaison meetings are well valued and deemed as effective in ensuring vulnerable expectant mothers and unborn babies are well supported and safeguarded throughout pregnancy. There is robust liaison in place between midwifery and health visiting on a fortnightly basis at ESH. This is in addition to regular visits three times per week to the hospital from the liaison health visitor who collects post natal information and distributes it to the relevant health visiting team. In contrast however, there is limited liaison between PRH and Horsham health visitors, and this is compounded by the lack of commissioned paediatric liaison role in PRH. Cases sampled highlighted gaps in information exchange which were negatively impacting on both teams' ability to support families. (**Recommendation 5.2**)

1.10 The comprehensive electronic "Eclipse" booking system at ESH automatically flags alerts on a pop-up screen if certain responses have been ticked as part of a midwifery consultation. This ensures all clinicians are fully aware of additional vulnerabilities and can offer ongoing support to vulnerable expectant mothers.

1.11 The named midwives at both ESH and PRH have good oversight of safeguarding cases and maintain a database of all “special issues” forms received from the midwifery team. Easily identifiable colour coded paperwork for safeguarding information is also in place which ensures all practitioners involved with the care of the woman can easily access the most up to date information.

1.12 We heard positive feedback about the “Partners welcome” initiative in place at both Worthing and PRH maternity unit. Fathers can stay overnight on the ward, with boundaries made clear to each family. Partners’ wishes are discussed routinely to ensure they are fully involved throughout labour and the immediate post natal period. However some staff raised concerns related to the lack of information currently collected about partner’s history both at booking and throughout pregnancy and the risks this may present to both staff and other patients on the ward.  
**(Recommendations 1.4, 5.5)**

1.13 Universal ante natal visits by the health visiting team are in place however the gaps in liaison between midwifery at PRH and the health visiting service mean that currently not all pregnancy bookings are received, therefore not all women in this part of the county are able to benefit from this enhanced support.  
**(Recommendation 5.4)**

1.14 The use of the health visiting family health and wellbeing assessment which includes maternal mood, is undertaken at the antenatal visit and again at the 6-8 week visit. Consequently, any areas of additional support are highlighted at an early opportunity and reviewed to ensure support is meeting the needs of the family.

1.15 Many health teams we visited do not routinely receive DV notifications and therefore health practitioners are unable to offer support, particularly at an early stage for families who are victims of domestic abuse. We heard of cases where the first time the health practitioner was aware that domestic violence was an issue was when the case was discussed at the Multi Agency Risk assessment conference (MARAC). This is a missed opportunity to ensure health staff are able to offer their unique contribution to supporting children and their families at an early stage.  
**(Recommendation 7.1)**

1.16 Midwifery services engagement with MARAC is well established however there is more to do to ensure that the trust safeguarding teams, particularly at ESH are fully involved. The named nurses report that they have made few referrals to the MARAC and that domestic violence incidents are referred to children's social care, therefore neither named nurse attends MARAC regularly. This means information is not informing risk assessments undertaken, particularly in the emergency department. **(Recommendation 4.3)**

1.17 The school nursing team work corporately because of ongoing capacity issues which can impact on visibility to young people and the strength of links with schools. As a result, school drop ins are operated on an ad hoc basis only where and when capacity allows, reducing the opportunity for young people to request health support.

1.18 Safeguarding risk assessment practice at ESH emergency department (ED) is robust. Assessment documentation is comprehensive and of good quality; using the CWILTED assessment model and there is a high level of compliance with good recording practice. Cases we reviewed in the ED demonstrated that all sections in the assessment documentation are routinely completed and that practitioners prioritise the safeguarding of children and young people.

1.19 Although there is no alert flagging system in use at ESH, in a number of cases reviewed in the ED, it was evident that the clinician had noted where there had been frequent or a high number of attendances and had interrogated the system to get further details of previous attendances. This information had informed their risk assessment of the current situation and is positive practice.

1.20 East Surrey Hospital has its own missing person policy which includes children that go missing or are likely to abscond. There is a high level of awareness among ED practitioners of the potential for adults and/or children to go missing from a busy ED, and all cases reviewed demonstrated that it is routine practice for clinicians to record the appearance and clothes of patients attending the ED.

1.21 We saw good awareness of the potential for hidden harm to children and appropriate risk identification demonstrated through cases we reviewed in the adult ED at ESH. The children's assessment tool at Crawley Urgent Treatment Centre (UTC) includes question prompts about relationships and family and also records who accompanies the child. We saw an example of prompt recognition of safeguarding risk to a vulnerable young person who was present in ED with adults in her family. This link has since enabled the young person's needs to be considered in a child in need meeting.

1.22 The Surrey & Sussex Healthcare trust has a robust did not attend (DNA) protocol in place. Where a child or young person fails to attend two or more times across the trust or where there is recurrent rescheduling of appointments; these cases are automatically discussed at the weekly safeguarding meeting. If a child or young person leaves the ED before being seen, notification for follow up is sent to community health services and primary care to ensure their needs are met.

1.23 Access to the mental health assessment team is rapid for patients who present at the UTC, as the mental health crisis team are located on site. As a result, in cases sampled where patients presented with clear mental health needs, initial triage by the UTC team was brief, without completion of the safeguarding questions. There was an assumption that the mental health team would take a more in depth history and identify any safeguarding concerns. As the two teams operate different IT systems, it is not possible for either team to ensure these prompts have been asked and that concerns have been identified and think family considered.  
**(Recommendation 2.1)**

1.24 At Worthing hospital, children's needs are well met by the paediatric ED accommodation. Extension of paediatric opening times until midnight is currently being considered and would enhance the service at a time when there is often a peak in presentations.

1.25 The establishment of a young person's drug & alcohol pathway at the EDs is a recognised area for improvement. Some work has been undertaken to develop a pathway, however, operational issues have yet to be resolved. The intended completion and launch of a robust pathway at Worthing is welcomed and its impact and reach will be monitored and reviewed to ensure that increased numbers of young people receive support at an early stage. There is no clear pathway for referrals of young people for substance misuse at ESH. Young people who present with substance misuse issues are given information and leaflets on support services only; therefore there is no assurance that they are being appropriately supported once they leave the ED. (**Recommendation 4.1**)

1.26 The health visiting and school nursing teams make good use of the Brearley risk assessment tool to help focus on case strengths and dangers, and this is updated regularly for families of concern to ensure support is increased if risks are escalating.

One case seen highlighted the benefits of an ongoing risk assessment tool in the school nursing service to ensure children were well supported as their needs changed. The description of "dangers" on the tool clearly articulated and tracked the escalation of needs as the impact of the mother's complex health issues led to neglect, and as the negative effect on the child's development and socialisation increased over a number of visits. Additional home visits were undertaken which had a good focus on the child, leading to early revisits and intensive support to prevent the home situation deteriorating. The persistent work by the school nurses in maintaining contact to support both the child and her parents, alongside robust joint working with the school ensured positive outcomes were achieved and the situation did not continue to escalate.

1.27 Young people have good access to full range of CASH and termination services around the county at three hub centres and a number of satellite clinics, all of which are well linked to the "Find it out" service for young people. Booked and walk in sessions are available, and all areas have some sessions up to 8pm across the week. Saturday morning clinics are a new development. Senior practitioners are based at the satellite clinics where there is a need for more autonomous decision making and interrogation of potential safeguarding risk.

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## 2. Children in need

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2.1 There is a well-established under 16 self-harm pathway in place at ESH and access to CAMHS assessment on the ward is reported to be good. Under 16's who attend ED with self-harm are always admitted to the paediatric ward in line with NICE guidance. In one case we sampled involving a young person living outside the area and where there were complexities and barriers around access to their local services, this did not cause delay in the young person having their needs assessed.

2.2 Currently young people attending Worthing ED with mental health needs do not have prompt access to assessment leading to unnecessary delays or admissions. We are aware that the recent agreement of a new CAMHS post within the ED should greatly enhance the service and ensure young people's needs are met in a more timely way.

2.3 We heard about and saw some CAMHS case examples where children and young people had experienced positive outcomes from the therapeutic intervention. However young people do not have prompt access to CAMHS services and performance on waiting times for specialist assessments such as Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) as well as the time taken for interventions to commence following assessment is an area of concern. An action plan is in place to address the backlog of young people awaiting intervention in Horsham in the short-term through the use of bank practitioners. However there is no clear plan in place to resolve the problem in the medium to long-term, particularly for young people with moderate mental health needs.  
**(Recommendation 3.1)**

2.4 Worthing CAMHS report a very positive and supportive relationship with the local paediatric ward where young people are admitted in mental health crisis. Individual plans are developed between the CAMHS duty worker attending the ward and ward staff to ensure the young person is supported effectively while in the paediatric ward. The CAMHS team leader also provides periodic mental health training to paediatric staff at Worthing hospital to ensure young people's needs are being addressed appropriately.

2.5 The CAMHS team leader attends the weekly multi-agency safeguarding meeting at ED which facilitates efficient information sharing and prompt access to clinical information on young people known to the CAMHS service who may have presented at ED. This promotes effective multi-agency care planning and support to vulnerable young people.

2.6 The STEPS support programme operated by CAMHS is effective in providing positive outcomes for young people, and two young people who have benefited from the programme are now acting as facilitators to further develop young people's engagement.

2.7 Adult mental health practitioners we met demonstrated that they understand their role in safeguarding children and that they prioritise the safety and wellbeing of children in their engagement with adult service users. We saw some case examples of good liaison between adult mental health practitioners and other professionals such as health visitors and school nurses. However managers acknowledged that there is scope to strengthen this to ensure this becomes routine practice rather than a reliance on practitioners only communicating at formal meetings and case conferences.

2.8 The perinatal mental health specialist service operating out of Worthing Hospital is identified on the intranet under complex care pathways but practitioners we met with were unable to access further information about the service and referral pathway through the intranet. As a result, there is a lack of clarity within adult mental health about the scope of and access to this specialist provision. (**Recommendation 3.2**)

2.9 Liaison between midwifery and GPs is an area of development. The midwife discharge letter sent to GPs from Worthing hospital has no section for detailing safeguarding concerns and only identifies that the safeguarding midwife is involved within the body of the letter. This is not easily distinguishable and leads to the risk that the GP, who will have ongoing contact with the family, may not be fully aware of any safeguarding concerns and therefore be unable to provide appropriate support. (**Recommendation 1.1**)

2.10 Bi-monthly 'families of concern' meetings held at GP practices we visited are routinely attended by the health visitor, the practice manager and a member of staff from the local family centre. Although the school nurse is invited they are currently unable to attend this forum due to capacity constraints. This meeting facilitates good information sharing and is able to direct vulnerable families into engagement with early help services. The new safeguarding lead GP at one practice is increasing the frequency of meetings to monthly to ensure that the follow-up on issues and actions by the professionals is robust and that families of concern are monitored carefully. This is a positive development in strengthening practice at the surgery.

2.11 In addition to the family of concern meeting, health visitors maintain good links with GPs by visiting practices on a regular basis to discuss and review all families on the health visiting caseload where safeguarding concerns have been highlighted. GP practices we visited were flagging children and young people on child protection plans or who were looked after, however there is no system in place to highlight children where there are other safeguarding concerns or additional needs that are not yet subject to formal child protection measures. In one case we sampled, this would have been beneficial to ensure the GP consultations were more fully informed and that cumulative issues were considered. (**Recommendation 6.5**)

2.12 Drug and Alcohol services (CRI) report that their liaison with midwifery at Western Sussex hospitals and ESH is improving and that they are now included in discharge planning for new mothers with ongoing substance misuse issues to ensure a holistic approach to care planning and longer term support is in place.

2.13 There is more to do within the school nursing service to clarify the role of practitioners outside formal child protection processes, where young people are vulnerable. Currently, there is a lack of clear expectations or criteria within the service about responding to identified risks. Cases sampled included a young person with a high level of attendances at ED; domestic violence identified within a family and young people with CAMHS involvement. There was a lack of clarity within the service as to when the school nurse should become involved. Some of these cases highlighted occasions where school nurses were not actively involved and there are no transparent criteria which triggers regular oversight and monitoring by school nurses, when they become aware of key information such as deliberate self-harm or domestic violence. This lack of cohesive multi-disciplinary working leads to the risk that children's and young people's needs are not being met. ***This information will be brought to the attention of Public Health England.***

2.14 The CASH "vulnerable young people clinic" pilot enables better liaison and follow up for young people displaying risky behaviours. One case we sampled highlighted how it has successfully addressed the immediate health needs of a vulnerable young person and probed her circumstances which then identified additional safety concerns. The multi-disciplinary meeting component of this clinic has enabled CASH professionals to discuss the concerns and potential risks and make an onward referral to children's social care in order to ensure the young person is safeguarded.

2.15 At present CASH work in isolation from other services and systems and have to go via the children's access point (CAP) in children's social care or their trust safeguarding team to make checks on people attending or ascertain more information. Accessing information via CAP can be a very slow process and impedes the team's ability to fully risk assess when the young person is present in the clinic.

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### 3. Child protection

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3.1 There is significant variation in the method for practitioners across West Sussex to make referrals to Children's Social Care (CSC) via the children's access point (CAP). Referrals from Crawley UTC use their electronic discharge note as the CSC referral. This means that whilst the clinical history taken is consistently copied, the form may not always clarify the risks and the purposes of the referral. Forms sampled were not clear enough in identifying the nature of the referral, the risks the practitioner has identified and the outcome desired. There is no consistent method of making referrals to the CAP in either CAMHS or adult mental health and it the responsibility of individual practitioners as to how the written referral is set out; for example via e-mail, letter or through the use of the referral form. As a result, there is no effective method to quality assure safeguarding referrals and promote continuous improvement. (**Recommendation 7.2**)

3.2 Following recognition that the quality of the referrals CRI made to children's social care was a national area for development, CRI has introduced a standard template known as a Statement of Referral (SOR) and all its practitioners routinely use this to make referrals. This is facilitating ongoing improvement in the quality of referrals made by this provider which is also making good use of examples of poor, satisfactory and exemplar referrals as training tools.

3.3 Most East Surrey Hospital ED referrals made to children's social care (CSC) that we reviewed did set out the risks of harm to the child or young person clearly. In one case however, key information about the circumstances precipitating the child's attendance at ED was recorded in the ED assessment documentation but not included on the children's social care referral. This could result in children's social care not having all relevant information to best inform their decision making about individual children.

3.4 Within all midwifery services, the quality of referrals to CSC and subsequent reports for conference was variable. In some cases, there was lack of clarity of the reason for the referral and the expected outcome. We did not see evidence of quality assurance of these referrals or reports by named midwives. (**Recommendation 7.2**)

3.5 We have seen and heard some good practice examples demonstrating effective risk assessment and prompt appropriate action taken by practitioners across a range of disciplines at ESH as a result of which, children were protected.



Child A attended a dental practitioner in the community due to toothache. The dentist referred her to the hospital dental service where the hospital dentist, who had recently undertaken the trust's level 3 safeguarding training, identified dental neglect, the child's unkempt appearance and some unusual behaviour. These were immediately recognised as safeguarding concerns and the named nurse was consulted. The named nurse contacted the child's GP who had not seen A for many years and through contact with the school nurse, it was ascertained that they had never attended any school and were illiterate. A strategy meeting was convened which was attended by the hospital dentist who had identified the concerns and the child was placed on a child protection plan at the subsequent ICPC. This case highlighted that A was protected promptly as the result of the dentist being trained at an appropriate level and therefore equipped to recognise indicators of safeguarding concern, taking swift and appropriate action.

3.6 Surrey & Sussex Healthcare trust named nurses are linked in to child protection pathways and routinely attend strategy meetings. They are encouraging frontline practitioners to attend these with the named nurse where they may have the key information to best inform the decision making of the meeting and to ensure the child is supported at an appropriate level.

3.7 Health visitors and school nurses are well engaged with formal child protection processes including attendance at conferences and core groups, and both teams use a standard format to ensure a consistent contribution is made by all staff.

3.8 Where child protection plans are in place for children whose parent is supported by adult mental health, copies of the child protection plan are not routinely sought and obtained by mental health practitioners. Plans are not uploaded onto the case record so that they are easily available to practitioner and managers therefore workers are unclear what their role in the plan is. It is essential that the child protection plan informs the care plan or agreement made with the client. This ensures that the practitioner can monitor compliance with the plan and report back to conference to best inform ongoing safeguarding decision making  
**(Recommendation 3.3)**

3.9 There is a clear expectation in adult mental health services that practitioners working with parents where children are subject to child protection plans will be part of the core group and attend child protection case conferences, whenever possible, as well as submitting written reports. We saw one case example where the named psychiatrist and an adult mental health support worker had attended the initial child protection conference and made a significant contribution to the conference decision to place the children on a child protection plan.

3.10 While managers and practitioners in both adult mental health (AMH) and CRI teams agree that in principle they would share relapse indicators and crisis plans with health visitors and other professionals, this does not happen routinely in practice. Cases sampled did not spotlight strong liaison or joint working between the health visiting, substance misuse and AMH teams, therefore opportunities to provide support to families are being missed. **(Recommendation 3.8)**

3.11 One practitioner in adult mental health told us that she regularly undertakes home visits to her clients and prioritises those where there are children in the household to ensure there are no additional environmental risks. This is not routine practice across the service however.

3.12 One GP we met was very aware of her safeguarding responsibilities and was able to demonstrate, through a case example, her diligence in following up concerns she had about a child with the ED and children's social care. Where she sees patients and children where there are known to be vulnerabilities or identified risk and child protection plans in place, she records her observations of the child's behaviours and demeanour and observations of interactions between parent and child. This is exemplary practice, giving the practice the opportunity to submit more detailed reports to child protection conference and thereby inform the conference decision making to best effect. Not all practitioners in the surgery recorded in this way however. One report submitted to a child protection conference recently set out basic information only, citing when the children had attended the practice and some additional information about the GPs concerns about one child's weight loss. The standardised template that is available for primary care contributions to child protection conferences is not universally used, which impacts on the consistency of these contributions. (**Recommendation 6.1**)

3.13 Whereas some GPs in the practices visited attend child protection conferences on occasions, there was a view that these are planned at short notice making it difficult to attend. Staff at the practice had not appreciated that the date of the next conference is recorded at the bottom of the minutes giving ample opportunity to plan how they can participate or attend. Heightening GP's awareness of this is likely to lead to increased participation in conferences. There has been little or no consideration of use of teleconferencing or other technology based means of increasing GP participation. (**Recommendation 6.2**)

3.14 There is more to do to develop liaison processes between school nursing and GPs. One case we sampled highlighted diligent work by the school nurse in following up the health needs of two children on child protection plans where the GPs lack of responsiveness led to risks that their health needs were unmet. However there was no communication between school nursing and primary care to ensure a holistic approach to supporting the family. (**Recommendation 6.3**)

3.15 There is a lack of clarity for CASH practitioners on the referral and outcome process for safeguarding concerns. In one case sampled, after initial liaison and referral to CSC, the CASH service did not have an update about outcome of the referral or whether the young person is now on a child in need or child protection plan. The CASH team reported feeling unclear about whose responsibility it is to follow up CSC, and there are no current standards and protocols in place. ***This information will be brought to the attention of Public Health England.***

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## 4. Looked after children

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4.1 Initial health assessments (IHA) are undertaken by appropriately qualified clinicians, including a GP with a special interest in unaccompanied asylum seeking children (UASC); however there are ongoing issues with timeliness of assessments, related to the notification process. IHAs are undertaken at the four child development centres ensuring that the setting is not overly clinical and therefore not likely to act as a deterrent to older children.

4.2 The support from the looked after children (LAC) nurse at IHA appointments when available facilitates immediate signposting for young people and their carers, alongside rapid follow up to ensure young people's high priority health needs are addressed.

4.3 On the rare occasion where an IHA has been undertaken by the looked-after children's lead nurse, this is subject to oversight and review by the designated doctor and subject to appropriate risk assessment. The service recognises that this is by exception only to ensure that a young person who will not engage in any other way, will consistently have their health assessed on entering care.

4.4 Overall the quality of IHAs and review health assessments (RHAs) sampled was good, with evidence that the nurse had taken time to engage and build a rapport with the child; this was particularly the case in the 0-5 years cases we looked at, where the LAC nurses are health visitor trained. The RHA's undertaken by the specialist LAC nurse team gave a good sense of the child as an individual and it was clear that all practitioners gave time to the young people to ensure a thorough assessment.

4.5 The LAC named nurse works with the cohort of UASC and undertakes their RHAs. She undertakes individual work with some UASC on particular health issues and these young people benefit from developing a relationship with a consistent health practitioner.

4.6 Most health plans reviewed were SMART although there were some where it would be difficult to track progress and timescales and accountabilities were not always clear. There was also a lack of transfer of targets and checks on previous actions from one plan to the next, and as follow up of actions cannot be monitored at present this is an area of development to ensure increased positive health outcomes. (**Recommendation 2.2**)

4.7 Young people have choices about where they have their RHA and the LAC nurses are able to offer some flexibility about location and time of day to suit the needs and wishes of the young person. However those RHA's currently undertaken by school nurses are not able to be conducted as flexibly, meaning there is inequity in the service as not all young people have this choice.

4.8 Birth histories were lacking in some cases but the LAC nurses demonstrated a high level of understanding of the importance of obtaining and securing parental birth history at the point the child becomes looked after. In one case the LAC nurse had challenged the view put forward by other professionals that as the child had been looked-after child previously, albeit 10 years previously in another area, there was no need to secure parental birth history.

4.9 The care leaver's offer is weak and is in the process of being developed. The service is not commissioned to work with young people over 18 but do on occasions if a young person is deemed to be in particular need of the looked-after child health team's support. Young people on leaving care are currently given a personalised health summary but the service is exploring how to strengthen this offer through the use of a health passport. We understand that the LAC nurse is consulting with the Children in Care (CIC) council on this.

4.10 Children who are looked after do not have access to specialist intervention services in CASH however the sexual health outreach worker nurse located within the CASH team is highly regarded and undertakes positive work with vulnerable young people and those in care particularly.

4.11 A specialist CAMHS service for looked-after children ( known as Looked after and Adopted children-LAAC -CAMHs) is in place, available to local children in care, although limitations on the scope of their work currently means many looked after children are seen in the generic service and are therefore subjected to standard waiting times. There are also issues with access to CAMHS for young people who are not deemed to be in a stable placement. This may mean that a highly vulnerable group of young people are not able to access the support offered by this service and therefore their needs are unmet. (**Recommendation 3.4**)

4.12 Within the LAAC CAMHs team, there is a 12 month wait for some LAAC interventions and this has been a stable waiting time for more than two years. While the young person is waiting for direct work to commence, LAAC identify an allocated practitioner who can be consulted by telephone for advice and support, however access to direct intervention is not timely. ***This information will be brought to the attention of the Local Authority.***

4.13 Although CAMHs and LAAC CAMHS do report into statutory looked-after child reviews, there is no routine liaison with the LAC health team or submission of progress briefings or reports to inform young people's review health assessments. This is a gap and we saw evidence of young people who are looked after with significant mental health concerns that are unknown to the LAC team and that are not part of their health plan. There is a significant risk that the RHA's and subsequent health plans are therefore not fully representative of a child's assessed emotional and wellbeing needs and that these needs are unmet. (**Recommendation 3.5**)

4.14 GPs, health visitors and school nurses are routinely contacted for information to inform the RHA however we did not see evidence of any contributions being received. This is a missed opportunity to ensure children's needs are being met on an ongoing basis. GPs spoken to were unaware of being asked to contribute information. (**Recommendations 2.5 and 6.4**)

4.15 Foster carers are engaged in the RHA process and are asked to complete an age specific carer's report. This has been recently redesigned by the looked-after child health team and is currently with foster carers for agreement.

4.16 GP practices we visited were flagging children who are looked after and all relevant documents were uploaded on System1. This included IHAs and RHAs with the health plan located on the front of the documentation to draw the GPs attention to its contents. This administrative change was at the suggestion of the previous named GP. However, GPs acknowledged they were not proactive in knowing this group of children and actively promoting health and wellbeing. The leadership of an overarching named GP would help safeguarding leads in practices to develop their roles and responsibilities in a consistent manner and ensure GPs are fully clear about their role in respect of LAC health.

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# Management

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This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

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## 5.1 Leadership and management

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5.1.1 Safeguarding leadership, advice and guidance is provided by the designated nurse, however the ongoing recruitment difficulties in securing a designated doctor and named GP are significantly impacting on her ability to drive forward safeguarding practice, and provide effective governance.

**(Recommendation 6.6)**

5.1.2 The current absence of a named GP role for the area is contributing to a lack of focused expectation setting in primary care and there is slow progress in ensuring effective primary care safeguarding arrangements.

5.1.3 The children's programme boards in each CCG, alongside the pan Sussex approach in some health areas are a useful mechanism to look at cross county themes to inform strategic direction for commissioning services for children.

5.1.4 It is not clear that the designated nurse for looked-after children has sufficient capacity (one day per week) to undertake the full range of responsibilities and ensure effective governance under the current arrangements for the role. This is in addition to the potential conflict of interest issues due to her operational LAC nurse role. **(Recommendation 8.1)**

5.1.5 The NHS professional's forum is well valued as a mechanism to discuss issues and for shared problem solving across the health economy. However there is more to do to develop contract specification and monitoring to ensure appropriate levels of scrutiny and accountability.

5.1.6 Workforce capacity, recruitment and retention across all providers are ongoing challenges and we did not see a robust proactive approach to overcoming these long term issues. There are capacity issues across named professionals in all midwifery services which is impacting on ability to quality assure and continually drive forward safeguarding practice under current capacity arrangements.

5.1.7 In order to ensure services learn from serious incidents and that practice is subject to continuous improvement, learning events and updated training has been developed. However we were unable to see the impact of this across many services we visited.

5.1.8 On the whole, the interface between health and CSC across West Sussex is working well. The plans in place to develop multi-agency strategies for LAC and care leavers; the Multi Agency Children Looked after improvement group (MACLAIG), and the Children's Access Point (CAP) into a Family Support pathway incorporating more health aims will aid collaboration and cohesive working to achieve best outcomes and progress for young people.

5.1.9 There is more to do to develop staff awareness across the economy on the use of escalation on cases where there is professional dissent. Whilst an agreed policy is in place, many practitioners we met with were unaware of both the policy and their role in highlighting professional disagreements across agencies.  
**(Recommendation 7.4)**

5.1.10 Surrey & Sussex Healthcare NHS Trust have recently increased the named nurse capacity for children's safeguarding by restructuring the full-time role into two part-time posts equivalent to a 1.3 whole time equivalent post. The named nurses report that this additional provision ensures sufficient capacity to meet the requirements of the role for the trust.

5.1.11 The re-build of the adult and paediatric EDs at East Surrey Hospital in the last two years has resulted in improved patient flow through the department. The paediatric waiting area is well equipped with a range of play and interactive equipment. The area is not directly observed by staff at the nurses' station; however, children and young people are only directed to the area if they are accompanied by an adult. Young people are also directed to wait in private rooms where deemed appropriate by staff, for example if a young person was in mental health distress or needed a quieter area than the communal paediatric waiting area.

5.1.12 The LAAC practitioners and team leader we met were not aware of any multi-agency CSE strategy in place although they are currently working with a child at high risk of CSE. The multi-agency strategy does not appear to be directly informing the work in this instance. CAMHs are currently not represented as part of the Multi Agency Child exploitation (MACSE) forum and this is an important disconnect as they are unable to exchange important information about young people who are at significant risk and assist with keeping young people safe.  
**(Recommendation 3.6)**

5.1.13 In adult mental health the named professionals are highly visible and practitioners and operational managers told us that they were available and that their leadership, advice and guidance is valued.

5.1.14 Not all adult mental health practitioners and operational managers have access to Framework I electronic system. The use of two separate and non-interfacing electronic recording systems within one service does not facilitate effective information sharing or safeguarding practice to ensure all practitioners are able to offer families optimum support. **(Recommendation 3.7)**

5.1.15 CRI have set a significant improvement and development agenda for the local service in its first year of operation, working to change practices and build a new staff team. CRI has undertaken its second section 11 audit independently and submitted this to the West Sussex Safeguarding Children's Board demonstrating the provider's commitment to improvement in safeguarding practice.

5.1.16 Where young people are transitioning from CAMHs into adult mental health, the protocol in place is for shared care and co-working between the two services for 12 months prior to transition. This would constitute best practice but is not currently happening in the trust due to the capacity pressures. Cases are currently being handed over in a single point of transfer at the young person's care programme approach review (CPA). As the result of a complaint, the general manager in adult mental health and the improvement manager are working to resolve this situation and an action plan is in place to address this and establish a more robust pathway with appropriate governance arrangements.

5.1.17 Monthly multi-disciplinary team meetings in CASH are part of a new strategy to strengthen oversight and decision making, with overview by the named nurse for safeguarding children, consultant, matron, lead health advisor and lead clinician to discuss and track the children most at risk to offer additional support to them. This is a positive development to ensure children and young people receive high levels of support.

5.1.18 The use of the Lillie IT system in all CASH service hubs ensures young people accessing sexual health services across the county are identified. However the system is stand alone and there is no linked systematic way to identify and flag those young people who are looked after, on a child protection plan or at risk of CSE. Information sharing arrangements across health teams and other agencies have not been developed. This impacts on the CASH team's ability to undertake a thorough risk assessment as they may not be fully aware of the young person's circumstances. It also highlights under developed partnerships to help safeguard young people who may be particularly vulnerable by failing to make connections across agencies.

5.1.19 The significant role for both CAMHs and CASH services in identifying and supporting young people at risk of CSE is not sufficiently recognised or represented in current partnerships and operational arrangements. Safeguarding practice and tracking in relation to young people who are vulnerable to CSE or victims of CSE is at an early stage, although it's reported that general awareness and understanding about the issue has improved in the county. The CASH modern matron was invited recently to sit on the LSCB CSE sub group but having attended once, it was concluded that her attendance was less effective at this strategic forum. She has now been invited to join the MACSE forum which until now hasn't had representation from CASH or CAMHs. The opportunity to track knowledge about young people across services who are engaging in risky behaviours is therefore less well developed than it could be. (**Recommendation 3.6**)



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## 5.2 Governance

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5.2.1 Safeguarding governance by the three CCGs is not robust. The bi-monthly update report on child safeguarding developed by the Designated nurses across Sussex does not constitute an effective safeguarding governance tool. The reports set out activity data only with no requirement for analysis or explanatory narrative. There is no reporting on outcomes which result from the activity. As a result it is not clear how the update gives the CCGs and WSSCB meaningful safeguarding performance information or robust assurance.

5.2.2 Governance and monitoring of provider activity and training compliance is underdeveloped. The limited capacity of the designated nurse means she cannot currently attend provider safeguarding and governance meetings and is less able to professionally challenge information reported. This has led to a stagnation of issues that are not being resolved in a timely manner. The recent recruitment of a deputy designated nurse will release additional resource to help resolve issues more promptly.

5.2.3 There is a robust process in place at the ESH ED whereby all under 18 presentations are reviewed by a senior practitioner to ensure safeguarding risk assessment has been comprehensive and any issues identified are acted upon appropriately.

5.2.4 The named nurses at ESH have developed a set of criteria to help support and guide ED staff in how to respond to any identified vulnerabilities or safeguarding concerns. This is in use at the nurse's station, displayed throughout the ED and is subject to regular review and updating by the named nurses as a result of learning from local and national incidents and SCRs and national guidance.

5.2.5 The weekly multi-agency safeguarding meeting held in ESH ED attended by named nurses, paediatric liaison health visitor, ED senior practitioner and Surrey social worker ensures all cases where vulnerabilities or safeguarding concerns have been identified are reviewed and discussed. The meeting is seen as an essential and effective component of the trust's safeguarding governance arrangements. There is no West Sussex children's social care presence however and this means that information sharing on West Sussex children and vulnerable families may be less well facilitated.

5.2.6 All notes seen in ESH ED were clearly legible, comprehensive and signed by the clinician making the record. This enables an effective audit trail and demonstrates that good accountability and recording practice is routine. Periodic audits are undertaken by the named nurses and there is continuous operational management oversight of practice as ED managers and senior practitioners check case records throughout the day.

5.2.7 Pre-populated text in some of the documentation in the ESH ED which states there are no safeguarding concerns could lead to contradictory or confusing information being shared across agencies. Practitioners are not deleting the pre-existing text in cases where it does not apply and this undermines the robustness of what is an overall sound approach to risk assessment, analysis and documentation reporting.

5.2.8 There is a high degree of risk that potential and known risks to children will not be appropriately alerted to other professionals and services where information systems across health do not interface. There is not due diligence paid to ensuring that flags and links to vulnerable or at risk children are entered onto all relevant systems. (**Recommendation 7.5**)

5.2.9 Operational governance in mental health for children's safeguarding is underdeveloped. There is no mechanism in place through which adult mental health practitioners and managers can easily and promptly identify that there is a CIN or child protection plan in place in individual cases, or that these are obtained by the practitioner and uploaded on the case record. Similarly, managers are unable to identify what cohorts of cases held by their service or team have children with known vulnerabilities or who are subject to child protection plans. This does not support the establishment of the "Think Family" model the service is reporting to be working towards. It also undermines effective caseload management, weakens information available to inform the joint strategic needs assessment and does not facilitate operational safeguarding practice oversight. (**Recommendation 3.9**)

5.2.10 Sussex Partnership Foundation Trust general managers do not receive regular updates on their team performance on the uptake and completion of both mandatory and desirable training. This does not assist managers in ensuring that practitioners are best equipped to discharge their responsibilities, nor to ensure improved performance on training which the trust acknowledges has been a long standing area of challenge. Performance reporting to managers is beginning to be introduced but is at an early stage. (**Recommendation 3.10**)

5.2.11 The multi-agency children looked after improvement group, MACLAIG, meets quarterly as a governance body for looked-after children, with a focus on improving performance. However, within health, the approach to quality assurance within LAC could be stronger. The LAC named nurse undertakes all quality assurance of assessments on West Sussex children placed out of county and returns assessments with which she is not satisfied. There is no recognised benchmarking tool or criteria based on NICE guidance for this quality assurance however to ensure consistency or compliance with national good practice. (**Recommendation 2.3**)

5.2.12 CRI are taking action to ensure that lessons learnt from a recent IMR become established practice. The "over the threshold" training to staff promotes the benefits and impact of undertaking home visits and what to look for in the home environment. Operational managers are checking that these are becoming established practice through regular audit.

5.2.13 An audit tool has been developed within CAMHs to monitor the impact of outcomes where young people have not engaged with the service and further assess this risk. This is with a view to develop a more robust approach to developing services for young people subject to child protection plans or where there are identified risks associated with the young person.

5.2.14 The Worthing ED demonstrated examples of monitoring the quality of practitioners safeguarding work compared to national standards and a solution focused approach when issues were identified. Ensuring that all ED locum staff understand and comply with trust policies remains a challenge. (**Recommendation 1.3**)

5.2.15 Quality assurance processes in relation to safeguarding referrals to children's social care are underdeveloped. Referrals seen do not set out the risks of harm to the child with sufficient clarity, and mainly consist of a chronology of events or summary of contact records. The inconsistencies in documentation are not facilitating practitioners in making good quality referrals which clearly articulate the risks of harm to the child. (**Recommendation 7.2**)

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## 5.3 Training and supervision

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5.3.1 Formal scheduled supervision arrangements across most health services are underdeveloped, and although there is regular supervision by the designated nurse with all named nurses, this is not stringently monitored. Adhoc advice and guidance particularly with the safeguarding advice line for community trust staff and GPs is well established.

5.3.2 Formalised supervision arrangements for both health visiting and school nursing services and recording until recently were robust, with very clear plans held on records. However, recent changes from regular individual supervision to group sessions has significantly impacted on some practitioner's ability to discuss all cases that are of concern, particularly those that may sit outside the periphery of formal child protection measures. As a result, some practitioners reported feeling less well supported in their role and there is a lack of management oversight of vulnerable children and their families. Current arrangements, where there is an emphasis on the practitioner to raise risk and concerns, give inadequate oversight for the levels of risk and complexity of some cases, particularly those that practitioners may not have recognised as such. (**Recommendation 2.4**)

5.3.3 There is no formal safeguarding preceptorship which aims to nurture community staff into safeguarding work, however all staff we spoke with felt well supported via mentors and joint working on cases to ensure they are able to identify and respond appropriately to safeguarding and child protection concerns.

5.3.4 Within the LAC team, supervision arrangements are robust and practitioners told us they felt they had appropriate protected time on a monthly basis to allow for discussion and analysis of cases.

5.3.5 CAMHS practitioners have regular clinical supervision which includes safeguarding, however, cases that are discussed in 1:1s and any decisions resulting from it are not noted on the young person's case record in line with best practice. Cases discussed in the multi-disciplinary meeting are being routinely recorded on the case notes.

5.3.6 Whilst most providers we visited had clear expectations for training and supervision, current arrangements and compliance is not meeting targets. Many staff we spoke with are not trained at levels commensurate with their roles and responsibilities. This review identified an issue at SPFT whereby there was a lack of clarity on the training level expected and a disparity between the online and paper policy. The SPFT training policy sets out that adult mental health practitioners will undertake level 3 children's safeguarding training, however, the trust's intranet policy sets the expectation at level 2. There is unsurprisingly, confusion among operational and strategic managers in the trust about what the expectation is. We understand this was being clarified as a matter of urgency following our visit.

5.3.7 Level 3 training arrangements across the county are not fully multi-agency in line with statutory guidance and best practice. While the LSCB multi-agency training is available to health practitioners, frontline staff, safeguarding professionals and operational managers told us of difficulties in accessing this training, therefore many health professionals reported they had attended single agency training only. There is no mechanism in place by which trusts can monitor health staff uptake and attendance at the multi-agency training effectively. (**Recommendation 7.3**)

5.3.8 Training and engagement of GPs in safeguarding remains a significant challenge. This is despite the development of specific in house training sessions within practices for level 3. We were told this is now being discontinued as uptake was low, and new approaches for level 3 training are being explored.

5.3.9 East Surrey Hospital staff have recently undertaken training on CSE delivered by the local police CSE lead, and one of the named nurses has been approved to deliver CSE training to trust practitioners to ensure all staff are fully informed on the risks and their responsibilities.

5.3.10 Children who attend ED at ESH are seen by appropriately trained practitioners. The provision of paediatric trained staff in the paediatric ED at ESH is in line with guidance with two paediatric trained nurses on each shift and an emergency practitioner on duty until midnight, after which the paediatric ward staff can be consulted.

5.3.11 The quarterly safeguarding professionals' network chaired by the designated nurse is described by named nurses as a very useful training forum and valuable to them in developing their role and safeguarding practice in settings.

5.3.12 The need for more focused safeguarding training for CASH services has been recognised by the trust as current training levels are insufficient for the role demands. A more service specific approach to training is being put into place by the Trust to be rolled out in April 2015.

5.3.13 In summary, practitioners across health services in West Sussex prioritise the safeguarding needs of children in their day to day work. However, capacity issues and transitional arrangements are significantly impacting on the pace of operational change and improvements in safeguarding and LAC services. There is more to do to further develop consistency, quality assurance and training across the health economy, to help deliver optimal outcomes for children and young people.

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## Recommendations

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- 1. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's with Western Sussex Hospitals NHS Foundation Trust should ensure**
  - 1.1 That the discharge letter between midwifery and GP's clearly sets out safeguarding risks and involvement of specialist midwife
  - 1.2 That specialist midwifery services are reviewed to include expectant mothers with perinatal mental health and substance misuse issues
  - 1.3 That processes are established to ensure that locum staff in ED are compliant with trust policies.
  - 1.4 That detailed partner information is captured at booking at updated throughout pregnancy
  
- 2. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's with Sussex Community NHS trust should ensure**
  - 2.1 That liaison between the emergency treatment centre and mental health assessment team at Crawley is strengthened with clear responsibilities for safeguarding assessment set out for practitioners
  - 2.2 That actions from review health assessments are reviewed routinely as part of next health assessment, with a process for monitoring follow up actions from health plans to ensure children and young people's needs are being met
  - 2.3 That a quality assurance process and use of a benchmarking tool for initial and review health assessments is established in the looked after children's team
  - 2.4 That supervision arrangements within health visiting and school nursing services are monitored and new styles of supervision are evaluated with frontline staff for effectiveness and quality
  - 2.5 That health visitors and school nurses contribute to information for review health assessments
  
- 3. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's with Sussex Partnership NHS Foundation Trust should ensure**
  - 3.1 That a long term plan to address capacity and waiting times for young people awaiting CAMHs intervention is established across the county

- 3.2 That arrangements for peri-natal mental health support is clarified for practitioners in the adult mental health team
  - 3.3 That practitioners in the AMH team are proactive in their approach to ensuring attendance at child protection meetings and that written plans are secured on client records
  - 3.4 That access to CAMHS interventions for children who are looked after is reviewed to ensure timely access to support
  - 3.5 That the CAMHS team routinely liaise with the LAC health team and contribute information to inform review health assessments
  - 3.6 That the CAMHS team are represented at the MACE forum
  - 3.7 That access to the Framework I system in adult mental health is reviewed for all practitioners
  - 3.8 That a process for liaison around relapse indicators between adult mental health and health visiting teams is formalised
  - 3.9 That a process is established for management oversight of children on child in need and child protection plans known to the Adult mental health team
  - 3.10 That a system to allow training compliance reporting is developed
- 4. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's with Surrey and Sussex NHS Trust should ensure**
- 4.1 That a young person's drug and alcohol pathway is established at East Surrey Hospital emergency department
  - 4.2 That specialist midwifery services are reviewed to include expectant mothers with perinatal mental health and substance misuse issues
  - 4.3 That engagement with the MARAC by named professionals at East Surrey Hospital is established
- 5. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's with Brighton Sussex University Hospital Trust should ensure**
- 5.1 That individualised birth plans are developed in a consistent format in conjunction with Horsham community midwifery team
  - 5.2 that robust liaison arrangements are established between Princess Royal midwifery service and the Horsham community team

- 5.3 That specialist midwifery arrangements for expectant mothers with perinatal mental health needs are reviewed.
  - 5.4 That robust arrangements are in place to ensure all maternity bookings at Princess Royal Hospital are reported to health visiting service for antenatal visits.
  - 5.5 That detailed partner information is captured at booking and updated throughout pregnancy with particular reference to ongoing assessment of risk related to “partners welcome” initiative at Princess Royal Hospital.
- 6. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG’s with NHS England should ensure**
- 6.1 That a standard format for GP written contribution to child protection conferences is used consistently
  - 6.2 That methods of increasing GP participation and attendance at child protection conferences are explored, including the use of technology.
  - 6.3 That robust arrangements are established to increase GP and school nursing team liaison
  - 6.4 That GP’s contribute information to the review health assessment process
  - 6.5 That a method of flagging vulnerable families in GP practices is explored
  - 6.6 That the recruitment of a designated doctor and named GP is prioritised as a matter of urgency with clear action plans in place if recruitment is not successful
- 7. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG’s with Western Sussex Hospitals NHSFT, Sussex community NHS trust, SPFT, Surrey and Sussex NHS Trust, Brighton Sussex University Hospital trust should ensure**
- 7.1 That an agreed process to ensure all teams are informed of domestic violence notifications is established
  - 7.2 That an agreed format for health teams to make referrals to children’s social care is established, with clear articulation of risk set out and management oversight developed as part of a quality assurance process
  - 7.3 That uptake of level 3 training is monitored to ensure all practitioners are trained in accordance with their level of role and responsibility.
  - 7.4 That staff awareness of professional dissent and escalation policy and local process is developed across all teams



7.5 That a standardised process is developed to ensure all relevant safeguarding flags and alerts are present across IT systems

**8. Coastal West Sussex, Crawley and Horsham and Mid Sussex CCG's should ensure**

8.1 That the capacity and job description of the designated nurse for looked after children is reviewed to ensure it reflects appropriate resources and in light of potential conflict of interest with operational duties

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## Next steps

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An action plan addressing the recommendations above is required from West Sussex CCGs within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk). The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.