

Review of health services for Children Looked After and Safeguarding in Portsmouth

Children Looked After and Safeguarding

The role of health services in Portsmouth

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Portsmouth. 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 NHS England.

Where the findings relate to children and families in local authority areas other than Portsmouth, 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.

About the review

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 health registered services 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.

How we carried out the review

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 115 children and young people.

Context of the review

The population of Portsmouth taken at the last census in 2011 was 210,029. The majority (98.5%) of residents are registered with a GP practice that is a member of NHS Portsmouth Clinical Commissioning Group (CCG). The latest published information from the Child and Mental Health Observatory (ChiMat) shows that children and young people under the age of 20 years make up 24.1% of the population of Portsmouth, with 19% of school age children being from an ethnic minority group. Generally, data shows that the health and wellbeing of children in Portsmouth is mixed compared with the England average.

The proportion of children under 16 living in low income families is 24.0%, significantly worse than the regional average of 14.7% and the England average of 20.1%. Family homelessness is also significantly worse at 4.2 per 1,000 as opposed to 1.6 regionally and 1.9 for England. The number of children in care is greater than the regional and England average with 73, as opposed to 52 and 60 per 10,000 respectively.

The infant (aged 0 to 1 year) mortality rate is lower than the regional and England average with 2.6 per 1,000 live births as opposed to 3.2 and 3.9 per 1,000 respectively. Furthermore the child (aged 1 to 17 years) mortality rate is significantly lower to the region and the rest of England at 6.6 per 100,000, compared with 10.7 and 11.9 per 100,000 respectively.

The ChiMat data shows a generally poorer picture for the general health of children and young people in Portsmouth with most of the attributes measured being worse than the rest of England. A minority of those attributes are similar to or slightly better than the England average. For example, immunisation coverage for all children is better than the national average, including the coverage for children in care which is significantly higher than the local and national average.

The rates of hospital admissions due to injuries, for both children aged 0 to 14 and young people aged 15 – 24, is significantly lower than the local and national averages. Furthermore the number of hospital admissions of young people with mental ill health conditions and young people aged up to 19 for asthma are lower than the national average. However, hospital admissions for those over 15 years due to substance misuse and for young people over 10 years through self-harm are significantly higher than both the local and national averages. Admissions for young people under 18 due to alcohol specific conditions were similar to the national picture but worse than those regionally.

The rate of under 18 conceptions is higher than both the local and national average. Obesity in children aged 4 – 5 years and in children aged 10 – 11 years is worse than the region and but similar to England. The rate of children with one or more decayed, missing or filled teeth, however, is significantly better than both the region and the rest of England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, Portsmouth had 225 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 30 of whom were aged four or younger.

The March 2016 DfE data indicates that nearly all of Portsmouth's looked-after children (97.8%) had received an annual health assessment, well above the average regionally (86.8%) and for England (90.0%). Furthermore, 100% of looked-after children aged under five had an up-to-date development assessment as opposed to 83.2% for the rest of England. As mentioned above, the DfE data indicates that 95.6% of looked-after children were up-to-date with their immunisations, higher than the England average of 87.2% and regional average of 82.1%. In addition 93.3% of looked after children had received a dental check compared with 84.1% in England as a whole and 86.5% regionally.

The commissioning and provision of most health services for children and young people are carried out by NHS Portsmouth CCG. Commissioning arrangements for looked-after children's health are the responsibility of Local Authority and NHS Portsmouth CCG and provided by Solent NHS Trust looked-after children's health team. The Designated Nurse role is provided by NHS Portsmouth CCG and the Designated Doctor and operational looked-after children's nurse/s, are provided by Solent NHS Trust.

Acute hospital services are co-commissioned with Portsmouth CCG, South East Hants CCG and Fareham and Gosport CCGs.

0 – 19 years integrated community health services for children and families, are commissioned by the Local Authority and provided by Solent NHS Trust.

The child and adolescent mental health services (CAMHS) are commissioned by Portsmouth CCG and provided by Solent NHS Trust, as are the mental health services for adults.

Integrated sexual health services are commissioned by Local Authority and provided by Solent NHS Trust.

Child substance misuse services are commissioned as part of a local offer in the Youth Offending Team and the Early Help and Prevention Team, provided by the Local Authority. Adult substance misuse services are commissioned by Local Authority and provided by Society of St James Recovery service who sub-contract Solent NHS Trust to provide an element of the service. The Alcohol specialist nurse service is provided by PHT.

The last inspection of safeguarding and looked-after children's services for Portsmouth that involved the health services took place in May 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children were judged to be 'adequate' and the effectiveness of services for looked-after children as 'good'. Recommendations for the providers arising from that review were considered during this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in June 2014. We have taken account of the findings of both of these inspections during this review.

All of the principal providers identified above have been inspected by the CQC through the course of 2015 and 2016. The findings of those inspections in relation to children and young people have been considered as part of this review.

The report

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.

What people told us

Young people and carers accessing CAMHS told us;

“CAMHS are fantastic and gave me loads of support when I had lots of issues.”

“CAMHS are great – get to see them straightaway. I’ve never had to wait.”

“When your own toolbox is empty, you can turn to them [CAMHS] for help. You can ring or email and get quick responses.”

“I have regular contact with the [CAMHS] team, they build relationships with us all – they know who you are and know your children. The team are experienced, knowledgeable and accommodating.”

Young people who have attended the Queen Alexandra hospital told us;

“I had to wait 5 hours in QA A&E once – they are a complete failure.”

“I had fantastic treatment at QA once and was in and out straightaway.”

Children and young people who are looked after and their carers talking about health assessments told us;

“We all have annual checks – it is a good experience but pretty much like going to the doctors.”

“The clinic comes to them [the looked after child] which is great. Everything is around the child’s choice and makes the health reviews a pleasure.”

“I have had a different one [looked after children’s nurse] every time. I think they should be the same one each time.”

“The medicals are just a form filling exercise for the council. My [foster] mum knows more about my health and helps me get what I need.”

The Children in Care Council said;

“We told the Doctor [for looked after children] at one of our meetings about consent section on the form, that it wasn’t suitable for older children, and so they changed it which was good.”

Foster carers told us;

“Once he became Looked After, investigations happened really quickly. He had a diagnosis, an EHC plan and a place in a specialist school within a year.”

“I’ve never had a problem getting a GP appointment, I can get one the same day because he’s in care.”

“The dentist prioritises looked after children. They talk to children about hygiene and do a proper check.”

“Opticians do not want yearly eye tests unless there’s a problem. The looked after children’s nurse listened to this and incorporated this into the health plan. I feel listened to.”

“I’ve had stoma care and PEG training at a time that suits me, they accommodated my working hours. I feel very lucky.”

A care leaver told us;

“There doesn’t seem to be much support for older children who leave care – it all seems to stop when you are 18.”

The child's journey

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

1. Early help

1.1 An effective early help offer is identifying need and supporting families well across Portsmouth. Public health nurses are an integral part of Multi Agency Teams (MATs) based in localities across the city. An enhanced key worker system means that families are working with one professional to address need. This key worker is supported by a team of professionals who provide advice, guidance and supervision to ensure that a co-ordinated package of care is delivered through the trusted lead professional who is working closely with the family. During our inspection we saw evidence of how this approach was helping to address need at the earliest opportunity which can avoid escalation into formal child protection processes.

1.2 Booking documentation in maternity does not identify potential safeguarding risks posed by a pregnant woman's partner sufficiently well. New documentation is under procurement to aid the early identification risks to women and the unborn from partners with concerning behaviours. This is an improved assessment tool but does not include mental ill health and hence does not support a robust risk assessment. Records demonstrated a lack of individual practitioner professional curiosity to routinely risk assess partners or consistently record their details fully. The absence of one complete record that reflects escalating or de-escalating concerns restricts the full consideration of risks to women and the unborn from their partners. **(Recommendation 1.1)**

1.3 Maternity staff do not consistently complete or record routine enquiry about domestic abuse. There is an expectation that midwives make this enquiry or ask the question about domestic abuse at least once as part of booking or at another time when it is safe to do so. However in records seen, completion of this enquiry was of variable standard and quality. Furthermore when a positive response is identified the level of risk was not measured using an appropriate tool to underpin any resultant action or plans to keep them safe. This practice limits the early identification of safeguarding risks to women and the unborn and subsequent action plans being made to manage risk they may experience from their partner. **(Recommendation 1.1)**

1.4 Most pregnant women benefit from access to a range of specialist and lead midwives based on the needs of women. In the absence of a specialist midwife for substance misuse, community midwives care for expectant women and liaise with adult substance misuse services. We are unable to comment on the effectiveness of these arrangements as record keeping is fragmented which limits access to a complete patient record.

1.5 The recent introduction of a dedicated team of midwives (CORAL team) for women with additional vulnerabilities is encouraging. This provision includes specialist support for expectant women such as those using substances; young parents aged under 19 years; young people who are looked after or care leavers and other complexities. This approach will support women, who sometimes find it hard to access mainstream services, with consistent maternity care. It is too soon to measure the impact of this new service as bookings have only recently started when the team became operational in June 2017.

1.6 The assessment of risk in pregnant teenagers for child sexual exploitation (CSE) in midwifery is underdeveloped. There is no evidence of routine enquiry in relation to CSE being made and the shortened CSE risk assessment tool was not used. This means there is a risk that vulnerable expectant females are not being identified and safeguarded. (**Recommendation 1.1**)

1.7 Templates developed jointly between the maternity service and GP leads, to capture pertinent information at the point of referral for maternity care, are not being used consistently or effectively by GPs. Most referrals seen from primary care lacked detail about any social elements or safeguarding history relating to women in their care. This limits the early identification of need and risk at the start of maternity care. (**Recommendation 1.1**)

1.8 Vulnerable families are well supported through joint meetings between health visitors and GPs. Linked health visitors generally attend meetings at their linked GP Practices to discuss vulnerable people and share information which aids joint working to help meet the needs of children and young people. Although GP surgeries have a linked community midwife they are not routinely part of these meetings, nor are school nurses. Pertinent information from these meetings is shared with school nurses via the electronic system however this limits opportunity to jointly consider risks between disciplines, agree any resultant actions and plans to support ongoing care. ***This issue has been brought to the attention of the local authority public health team.***

1.9 Health visitors routinely make enquiries of women about the risk of domestic abuse at each of their 'healthy child programme' contacts, as long as it is safe to do so; more often if they are providing targeted support. This approach recognises that risks of domestic abuse can evolve due to changing family dynamics brought about by a new baby and ensures that health visitors understand those risks as they might apply to individual families they are working with.

The school nursing service provide emotional support to children with additional needs as part of their Universal Plus offer. For example, one young person who was experiencing anxiety and relationship problems due to low self-esteem and their appearance was well supported through enhanced contacts by the school nurse. The young person was then able to access additional services that met their particular needs. The outcome for this young person was improved resilience through the practitioner's restorative approach.

1.10 The Family Nurse Partnership service in Portsmouth effectively supports a small number of young women up to the age of 21 with their first pregnancy and up to the child's second birthday. This targeted service helps to meet any additional needs of this vulnerable cohort of young mothers through focussed interventions. Feedback from those accessing the service has been positive and personal outcomes for parents and infants have improved.

1.11 Children and young people in Portsmouth benefit from the provision of a fully integrated sexual health service. This provides children and young people with access to a range of services including advice, contraception, sexual health screening and treatments. The service is provided Monday to Friday with no weekend provision. There is a dedicated young person's clinic once a week with additional access available in the "all ages" service. Harder to reach children and young people benefit from access an outreach service which works flexibly with those who may not engage with the mainstream offer. Outreach staff report good links with the teenage pregnancy midwives which contributes to effective joint working and improves outcomes for children and young people.

1.12 Young people can only access support for substance misuse problems through MATs, unless they are open to youth offending or children's social care. Each MAT has a substance misuse practitioner who offers support predominantly in a consultancy approach to a key professional working with the young person to enable them to deliver drug and alcohol interventions. We were assured that if young person required specialist drug or alcohol direct work, this would be made available to them. At present this approach has not been formalised or underpinned by agreed policy or pathways to demonstrate how this would be facilitated. Given that this is a recent change it is too early to measure the impact on the quality of the services received by children and young people in Portsmouth and whether it meets their needs. ***This issue has been brought to the attention of the local authority public health team.***

1.13 The QAH adult emergency department do not have robust arrangements to identify and record details of the hidden child/children linked to adults attending with concerning behaviours. Staff do not routinely collect or record details of children associated with adults who attend the ED as standard and both the electronic patient record system and booking in documentation lack any prompts to ask about children's details. We did see examples of professional curiosity shown by triage staff, who as individuals were robust in their approach to identify children who may be at risk from adults with concerning behaviours, but this was not systematic or supported by formal processes. This means that the trust cannot assure itself that all vulnerabilities and risks to children resulting from the attendance of the adult are being routinely identified and as a result, some children may be left at risk. **(Recommendation 1.2)**

1.14 When a child or young person attends the children's ED there are opportunities to identify and capture potential safeguarding information but the effectiveness of this is limited by inconsistent practice. Records examined showed good detail at booking in around who has accompanied the child to the hospital and their relationship to them which supports enquiries around consent and the appropriateness of this relationship. However, the 'mandatory' safeguarding screen contained on a child's electronic record, is at times, incorrectly completed or bypassed by practitioners. This tool is intended to prompt risk assessment of children for any safeguarding concerns and therefore if not used correctly, does not provide assurance that all children are subject to a thorough risk assessment of factors which may be linked to safeguarding concerns and therefore opportunities to safeguarding them may be missed. **(Recommendation 1.3)**

1.15 Children and young people are able to access a full range of specialist mental health services. All referrals into CAMHS are made via a well-established Single Point of Access (SPA) team. To increase accessibility SPA workers operate a drop in services one night a week in a city centre hub, and school clinics held in two thirds of secondary schools once a fortnight. Practitioners reported a good uptake of the drop in sessions which allow young people to come and discuss any concerns they may have in an open manner.

A young person who was nearly 18 was taken to hospital emergency department, assessed by CAMHS and was admitted to the hospital as an inpatient. This was followed by inpatient CAMHS admission. Initially there was deterioration in the young person's mental health condition, requiring more intensive support but following this a good recovery was made and the young person was discharged to adult mental health services for ongoing community psychiatric support.

The records demonstrated effective joint working between adult mental health and CAMHS inpatient services, particularly in respect of planning for discharge from inpatient services, which enabled a smooth transition to ongoing care with adult mental health services.

1.16 Good progress is being made in identifying and assessing risk to children within adult mental health services. Adult mental health practitioners are routinely enquiring about children in initial assessments and we were advised that this included the identification of children in the client's household. The assessment proforma does not extend into exploring the wider circle of children or young people that the adult may have substantial contact with and this is an area for improvement.

1.17 Children of adults who misuse substances and access the adult recovery service are safeguarded well. The 'Think Family' approach is embedded within the adult Recovery service run by Society of St James (SSJ). Home visits are conducted as part of the assessment process with consideration for children at all stages. Case records reviewed were clearly child focused with sufficient detail about the child's presentation and demeanour and parental interaction. A bespoke and interactive electronic patient record system allows the service to clearly document relevant safeguarding information. This facilitates good identification of risk and the interactive genogram supports practitioners to consider other children living in the home, or those in care of the local authority. Examples seen thoroughly assessed the child's needs, explored the impact of the adult's substance misuse on their capacity to parent well and keep their children safe, as well as considering other environmental or familial factors which may have placed the child at risk. This is good practice.

1.18 The assessment of risk of CSE is underdeveloped in GP practices. Practices visited do not make use of the shortened CSE checklist in their assessments of children and young people. In one practice we could see that the template for this assessment was not easy to find and in another the GP was not aware of the shortened tool. Children and young people at risk of, or victims of, CSE accessing primary care may not have their needs fully assessed restricting their ability to be effectively safeguarded. (**Recommendation 2.1**)

2. Children in need

2.1 Expectant women with mental health needs benefit from access to a specialist midwife for perinatal mental health. The specialist midwife carries a caseload of more complex cases and provides support and some input to women cared for by the community midwives. The specialist midwife provides two weekly clinics for high risk women that are well attended and there are plans to start joint clinics with the psychiatrist in September 2017.

X had a history of postpartum psychosis and had needed in-patient admission. When X became pregnant again, she contacted her previous adult mental health worker to advise her of the pregnancy. The practitioner responded appropriately; X was prioritised within adult mental health services, a risk assessment was completed and a care plan was put in place to support her and safeguard the unborn baby. Effective preventative and proactive joined up work was carried out, including home visits and good liaison with the perinatal midwife. A birth planning meeting took place and arrangements were put in place to meet X's specific needs. X was able to remain at home with her family during and after her pregnancy and hospital admission was avoided.

2.2 Portsmouth women experiencing low to moderate mental health difficulties are benefitting from a new locally delivered specialist perinatal mental health pathway introduced from April 2017 provided by Southern Health NHS Foundation Trust. This brings Portsmouth into compliance with NICE guidance as previously specialist treatment had to be accessed outside of Portsmouth. The new service offers domiciliary visits from a practitioner and a support worker although it is too early to evaluate the impact and outcomes of this new service.

2.3 There is a gap in service provision for some pregnant women who experience mental health crises whilst an in-patient on the midwifery unit. Portsmouth CCG have confirmed that the onsite crisis mental health team provide acute care for women who are inpatients on the maternity ward at first presentation but do not offer ongoing inpatient support. Therefore women who experience crises whilst an in-patient on the maternity ward, who are already open to a mental health service, are not able to receive support from the onsite crises mental health team. In one case a woman had to leave the maternity ward and attend a community clinic appointment. Furthermore, not all maternity staff have received training in mental ill health which may impact on their ability to effectively meet the mental health needs of women in their care in particular when in crisis. (**Recommendation 3.1**)

2.4 Pregnant women who have a learning disability can be issued with a learning disability passport. However a recent audit has identified that not all staff are aware of these passports therefore limiting their ability to effectively support an expectant women with additional need. (**Recommendation 1.4**)

2.5 Children in need and their families benefit from good involvement and support from health visitors and school nurses. These practitioners are active participants and key influencers in child in need processes. In records we looked at we noted that health visitors are always involved in team around the family (TAF) meetings and contribute an analysis of their work with families. Records relating to this work are consistently of a high standard, setting out the clearly the progress of the TAF towards meeting needs and the plan for forthcoming work. This is particularly beneficial in those cases when health visitors take on the role of lead professional when a child in need plan is stepped down to early help.

In one of the cases we looked at in the health visiting service we saw that a family who were receiving statutory intervention under a child in need plan were referred into the service for targeted support led by the family health visitor. There was a history of domestic abuse between parents, maternal ill-health, poor parenting skills and the children had some developmental delay.

Improvements in the family home and parenting had led to the stepping down of the child in need plan as it was agreed that the family's needs could be better addressed through a restorative approach led by a health visitor. The early help assessment, created as part of the step-down arrangements, identified specific outcomes within achievable timescales and were a continuation of those set out in the previous child in need plan.

Electronic records made by the health visitor provided good detail about the work carried out with the family towards meeting agreed outcomes. The health visitor also worked closely with other professionals, particularly within the school, to ensure the children were properly supported following an incident where the risk of domestic abuse was heightened.

The health visitor continued to work with the family to ensure that the children's needs are met within early help.

2.6 LSCB escalation processes, where there are areas of professional disagreement, are not always fully complied with by all school nurses. In one case we looked at we noted that a practitioner had a professional difference of opinion about the level of risk and the outcome of a child in need meeting. This was appropriately raised by the health practitioner concerned through an email to the social work colleague. However, when the issue remained unresolved there was no further use of the appropriate escalation process involving managers. In this instance there was a further delay of almost two months until the case was re-assessed by children's social care to consider statutory support as a child in need. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.1)***

2.7 The integrated sexual health service provide specialist clinics in addition to their universal offer. There are dedicated appointments available for people with additional identified needs or vulnerabilities such as learning disability or child sexual exploitation risk. The appointments allow for more time to be spent with the individual to help identify and meet their sexual health and wellbeing needs. Records seen demonstrated evidence of good liaison across agencies with good joint working to meet the needs of vulnerable children and young people accessing this enhanced service.

2.8 However, arrangements for identifying risk in children and young people attending integrated sexual health services are too variable. We saw that whilst some records had alerts which had been added to indicate vulnerability, these were not always updated with the most recent information and did not fully reflect the child or young person's needs. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.2 and 4.3)***

2.9 The electronic record keeping system used in the integrated sexual health service does not fully support practitioners to ensure completion of the mandatory checks for domestic abuse and risk assessments for 16 and 17 year olds. Practitioners can bypass these fields and may miss opportunities to identify risk and intervene early to safeguard those in their care. Furthermore it does not support practitioners to record the details of children linked to adults that attend. This is a missed opportunity to aid the identification of hidden children linked to adults that present with concerning behaviours or where there may be risks to children such as female genital mutilation. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.2)***

2.10 Practitioners on QAH paediatric wards are not supported to effectively safeguard children and young people due to a lack of appropriate protocols or basic checklists to assist assessment and care planning for those who are mentally unwell or at risk of self-harm. There are no environmental risk assessments undertaken and no individual risk management plans developed for each child. The paediatric ward manager told us that a new risk assessment pro-forma is in development in partnership with the CAMHS liaison psychiatrist but the timeline for this to be introduced was unclear. In addition there has been very limited training received by paediatric nurses around supporting children with mental health needs. There are plans in place for CAMHS to train paediatric nurses with mental health competencies however this is only an interim measure. ***(Recommendation 3.2)***

2.11 In the QAH we saw case records for a child on the ward who had been assessed by a CAMHS practitioner that day, however a copy of the completed risk assessment was not provided to the ward staff and we were consistently told that these are never left with the ward. This means ward staff are not fully informed about how to provide best care and may not be sufficiently well-sighted on the risks of the child attempting serious self-harm. ***(Recommendation 3.2)***

2.12 Children and young people up to 16 years of age who attend A&E with self-harm or mental health concerns are usually seen quickly by CAMHS. However, the arrangements for those children aged 16 and 17 are less secure. Portsmouth CAMHS are part of a self-harm rota shared with Hampshire and the out of hour's service. Most young people this age, who present to A&E with self-harm or mental health concerns, are admitted into the paediatric ward where CAMHS are prompt in seeing the child on the same, or the following day. However there are concerns about young people aged 16 and 17 being placed on adult emergency department observation wards thus being seen by the adult mental health liaison team. Managers were aware that this is an area which needs to be addressed and made more robust but at present progress is at an early stage in finding a solution to rectify this situation. (**Recommendation 3.3**)

2.13 Appropriate and timely arrangements are in place for children and young people who meet the threshold for acute CAMHS to be assessed by the CAMHS SPA and allocated onto a care pathway. Children are prioritised according to their needs and the majority are seen within 10 weeks. Appointments for those children with more acute needs are escalated and they are seen more quickly. Whilst a child or young person is waiting to access CAMHS they and/or their family are offered support through telephone contacts. This approach helps to reduce the feeling of isolation and stress for children and young people whilst waiting to access the service.

2.14 CAMHS have developed and successfully implemented a crisis care post to co-ordinate, deliver and evaluate care for children and young people with a focus on helping to prevent admission to hospital. This practitioner provides assessment, treatment and risk management of a young person as well as, supporting their family and network to plan for, and manage crisis.

2.15 We were not assured on the transition process for those young people who are turning 18 and have an ongoing problem with substance misuse. We were not provided with any evidence of a transition policy or care pathway to support transition into adult substance misuse services. This means that some young people may not benefit from a clear, planned handover into adult services. ***This issue has been brought to the attention of the local authority public health team.***

3. Child protection

3.1 Portsmouth City Council children's social care is introducing a restorative practice model to child protection work. The council reports that health agencies are well engaged with the introduction of this model and that health's uptake of training to support the model's introduction is positive. This approach supports increased consistency in child safeguarding practice across Portsmouth.

3.2 There is a clear, single point of referral into children's social care with an explicit expectation that contacts and referrals to the Multi Agency Safeguarding Hub (MASH) should be followed up in writing using the Inter-Agency Contact Form (IACF). The IACF has been revised in light of stakeholder feedback to provide more useful prompts and steer to practitioners making referrals. We saw one recent referral in the MASH from a student health visitor which was of excellent quality; setting out clear and concise details of the family circumstance. The concerns of the practitioner about risks of harm to the unborn were articulated succinctly but explicitly, facilitating effective decision-making in the MASH.

3.3 Referrals from health services to children's social care did not always include ethnicity or first language. A lack of understanding of ethnicity, cultural beliefs and norms and first language may impact significantly on the best delivery and provision of health support to a vulnerable family and clearly impede effective communication and engagement with a family.

3.4 The Portsmouth MASH has been established since November 2015 with effective input by a CCG funded full time health navigator complemented by a 0.8WTE health visitor working in the Early Help hub. The health navigator is a confident and valued partner in the day to day operation and decision making of the MASH.

We saw good examples of effective advocacy by the health navigator to ensure that health specific safeguarding risks were appropriately escalated when concerns had been referred into the MASH. The health navigator highlighted the impact on the health, wellbeing and safety of the young people as a result of not being taken to important medical (CAMHS and physical health) appointments by their parents. As a result of the health navigator being able to articulate the risk and impact, the cases were reassessed in the MASH and taken through section 47 child protection proceedings so that the health and wellbeing of the young people was safeguarded.

3.5 The MASH health navigator does not routinely discuss cases or request updates from health practitioners about children referred to children's social care but instead will access the electronic health records that are available. The effectiveness of this is reliant on having access to all record keeping systems in Portsmouth; the record having an agreed sharing right; and that it is up to date. However, in the case of one local GP Practice not using the shared electronic record system the navigator only has sight of hospital records to identifying any appointments or ED attendance.

3.6 In an attempt to increase contact between MASH and primary care, one GP has spent time visiting the MASH. This was a good opportunity for the practitioner to raise the understanding of how the MASH operates across primary care, thus facilitating stronger engagement likely to safeguard children more effectively.

3.7 Not all information regarding domestic abuse incidents is shared effectively with health professionals. Children and young people who live with domestic abuse are identified through police domestic abuse notifications that are sent to MASH services. However it is only the most serious incidents are entered onto the electronic health record system by the health navigator. This means the information is available to public health nurses and most GPs is limited.

3.8 Families who are living with serious domestic abuse are discussed at the local MARAC. Arrangements are well embedded for the health input to be co-ordinated through Solent NHS trust's safeguarding team. This ensures a consistent and summative presentation of that information where families have been supported by a number of different health professionals.

3.9 We observed that primary care is not well engaged in the local MARAC arrangements and it was evident in GP practices visited that information sharing with MARAC is not well developed. Practices were not able to identify MARAC cases to allow us to assess the effectiveness and impact on children and young people accessing their GP. Not being aware of domestic abuse incidents limits the opportunity to link family members in primary care patient records, undertake any follow-up actions and keep the profile of these issues high in the service. **(Recommendation 3.4)**

3.10 We saw evidence of good practice in safeguarding children and young people in GP practices visited. Children and young people that are looked after, subject to CIN plans or child protection plans are visible to GPs through the good use of alerts. This can support practice staff to consider the known vulnerabilities linked to the alert to inform their assessment of their presenting condition. GP practices visited reported though they had limited capacity to be able to attend child protection conferences they do submit reports. In one practice a report examined contained information about the children and all pertinent family members linked to children's social care involvement. This means that important information was shared and considered as part of the conference.

3.11 The majority of health practitioners across Portsmouth are routinely participating in child protection strategy meetings. Where a case is already known to a health practitioner, this practitioner or representative from the service will attend or participate in the strategy meeting; where this is a new case, then health are represented by the health navigator. Strategy meetings are held in venues across Portsmouth, including the hospital ED. This flexible approach helps to improve attendance from health partners and is good practice in line with national statutory guidance (Working Together 2015).

A student health visitor completed an antenatal home visit with Woman A and established a positive relationship with her. This opportunity to build a relationship in the ante natal period was instrumental in creating an environment where Woman A disclosed that she had experienced FGM as a child. The health visitor identified through observations and discussion that Woman A was not bonding with her unborn child and had not made preparations for the baby's imminent birth including the provision of necessary equipment.

Furthermore there was a volatile relationship with the baby's father and there had been previous domestic abuse. The health visitor made a comprehensive, well evidenced referral to MASH, setting out clear and concise details of the family circumstance with a clear analysis of risk. MASH arranged for an urgent pre birth assessment and a plan was put in place to protect the infant at birth.

3.12 Expectant women who are victims of FGM are identified through the effective use of a risk assessment tool and appropriate arrangements are in place to identify female children at risk of FGM. There are good pathways for women to access medical help at the perineal clinic with additional support in the community from a dedicated worker as part of southern domestic abuse service. In one case sampled, midwives identified possible risk to the two year old daughter of a woman affected by female genital mutilation and made a referral to children's social care to consider further risks to the child.

3.13 We were not assured on the robustness of multi agency planning to safeguard vulnerable newborn infants. Documentation held in health case records did not evidence robust multi-agency planning to safeguard vulnerable newborn infants. Multi-agency safeguarding pre and post birth plans were not evident in records sampled. As a consequence we could not review the quality of the agreed multi-agency plan to safeguard the unborn/new-born. It is not clear how this important information is shared to fully inform the ongoing care of women/unborn/new-born and ensure there is a complete safeguarding record. Highly visible safeguarding alerts are created by the safeguarding team at 34 weeks but these are single agency plans. In the absence of any agreed and shared multi-agency pre and post birth plan from children's social care, this alert is the safeguarding plan. This arrangement does not align with the LSCB Unborn and Newborn Baby Safeguarding Protocol (2016). (**Recommendation 1.5**)

3.14 We saw strong child protection arrangements within health visiting and school nursing. Public health nurses working with children subject of a child protection plan routinely attend core group meetings. During core group meetings all practitioners provide updates on the progress of their work and rate progress according to a traffic light system. This is used as a summative assessment to report on progress for the review conference and helps accurate information to be presented to conference. Families benefit from having to review one comprehensive report rather than multiple reports from different practitioners. This is a recent initiative, however, and its effectiveness has yet to be formally evaluated.

3.15 Reports submitted by public health nurses for initial child protection conferences are of a very high standard. In all of the cases we reviewed we noted very detailed factual information supported by thorough analysis using an assessment framework. Reports are shared with families prior to conference which gives them the opportunity to challenge if necessary. This robust approach helps to ensure that decisions made at child protection conferences are evidence based and accountable.

3.16 School nurses carry out health needs assessments for every child subject of a child protection plan, a child in need plan or who is supported through early help. In assessments we looked at, the 'voice of the child' was prominent with clear identification of additional health needs. This means that health interventions are targeted for any particular child, in accordance with their wishes and feelings.

3.17 Home educated children and young people do not benefit from access to the school nursing service. Practitioners we spoke with were not able to identify this population and as a consequence this limits the provision of their service. It is well evidenced in findings from serious case reviews that this cohort of children can be particularly vulnerable. In a report to Portsmouth LSCB (July 2017) education and public health are taking steps to improve on this but it is in early stages. ***This issue has been brought to the attention of the local authority public health team.***

3.18 Children and young people are not benefitting from a cohesive and holistic approach to identifying and responding to potential risk of CSE within universal health services. We saw a number of cases within school nursing and family nurse partnership where the opportunity to identify and assess CSE risk had been missed. ***This issue has been brought to the attention of the local authority public health team. (Recommendation 4.3)***

A young person known to be at risk of CSE was brought into the QAH ED by ambulance due to injuries sustained from a road traffic accident. Given the presenting situation and associated risk factors, the assessment lacked professional curiosity and there was no evidence of exploration into the lack of parental supervision or appropriateness of the relationship with the person in the vehicle. Contact was made with Social Care however there was a missed opportunity to make use of the shortened CSE risk assessment which would have facilitated the opportunity to gather more information to inform work with this young person.

3.19 We saw evidence of safeguarding referrals made by practitioners in the children's ED describe risks to children well. However, this good practice did not always translate into a comprehensive discharge summary to the child's GP which could impact on effective safeguarding arrangements in the future. **(Recommendation 1.6)**

A baby was brought in the QAH ED by parents for treatment. They disclosed that the baby suffered an accidental injury the previous day and now had swelling on the head. The clinician contacted children's social care to check if the family were known and it was confirmed that a series of assessments had been undertaken despite the father stating that they were not known to children's social care.

The child was found to have a fractured skull. The patient record demonstrated good observational recording by the clinician including noting delayed mobility in the injured child and detailed recording of his discussions with the father, including father not being truthful about contact with children's social care. The clinician also noted that the parents did not understand the seriousness of the injury to the child.

The GP notification letter, however, included none of the information regarding possible neglect and the clinician's concerns about parental capability and understanding.

3.20 Paediatric liaison arrangements are not sufficiently well developed to ensure timely information sharing arrangements following a child or young person's attendance at the QAH ED. Cases seen demonstrated that information was not shared in a timely manner and lacked sufficient detail meaning key child safeguarding information is not part of the child's community and primary care record and cannot be considered as part of any ongoing care assessment and planning. **(Recommendation 3.5)**

3.21 The provision of a safeguarding liaison role being undertaken by a senior paediatric sister one day per week is a positive development. This will help to address issues around quality of information, however, given that all reviews undertaken are retrospective and only on cases where concerns have already been identified, there remains a delay in escalating concerns. Consequently we saw evidence in one record in the 0-19 service where the opportunity for early intervention by the school nurse had been missed. ***This issue has been brought to the attention of the local authority public health team.*** **(Recommendation 3.5)**

3.22 Despite the introduction of the safeguarding liaison role, there is no operational oversight by a shift supervisor or lead practitioner in either Adult ED or Children's ED to ensure that all safeguarding issues have been identified and considered; that practitioners are making the optimum decision about whether a cause for concern is needed and what information this should contain. The content and quality of referrals to children's social care are not checked prior to their submission and we saw case examples of key information omitted from the safeguarding referral. This means that children and young people may not benefit from a timely and appropriate safeguarding response and experience delay in support being put into place to reduce risk. (**Recommendation 3.5**)

3.23 CAMHS practitioners are engaged in child protection processes and this work is given high priority. Where appropriate staff attend meetings to provide consultation and strategies to other workers even if the child is not yet open to the service. Furthermore IACF are routinely completed to a good standard where risks to a child or young person's safety are escalating or when it has been identified that a child or their family would benefit from additional help.

3.24 CAMHS practitioners report they do not receive copies of the minutes relating to child protection meetings they may have attended. This does not give them opportunity to review the content of any plan or that their contribution has been accurately represented. It also means that they do not have a complete record and staff were aware that this process could be made more robust.

3.25 The quality of record keeping in adult mental health was good and information from other professionals was used effectively to inform risk assessment, care planning and decision-making. Relapse indicators and crisis plans generated paid good attention to the adult's parenting capacity and the impact on children of deteriorating parental mental health. Evidence seen in the records demonstrated effective joint working with children's social care and school however work with health visitors or school nurses was not as developed and it was not common practice to share crisis plans with these health professionals. This is a missed opportunity to ensure that all professionals who may be visiting the home can be well informed about early indicators of relapse and support parents into appropriate mental health support at the earliest stage. (**Recommendation 4.4**)

3.26 Vulnerable children and young people who live in families with adults who have mental health illness and/or substance misuse are identified and safeguarded well. Managers and practitioners within adult services have a clear understanding of their roles and responsibilities in safeguarding children and young people while working with adult clients. We saw a number of case examples where practitioners from both services had identified safeguarding concerns, discussed these with their line manager in the first instance and made appropriate and good quality referrals. Recovery practitioner's records noted an appropriate level of challenge and escalation when a practitioner's concern of multi-agency management arose. Adult mental health practitioners attached additional risk assessments and mental health history information where it was useful to inform effective decision making in the MASH. This approach supports using specialist knowledge to inform risk assessment and decision making and safeguards children.

3.27 Adult mental health and substance misuse services routinely attend child protection conferences and key meetings. Contribution to meetings were of good standard providing analysis of potential risk to children to assist the decision making process. All records examined contained appropriate detail of the outcomes from meetings and practitioners are positively encouraged to maintain a prominent role in the child protection process. In most records seen we found evidence that minutes from conference and core groups were received and uploaded to the system providing clear evidence of their role within any plan around the child.

3.28 The highly visible safeguarding flagging system within the Recovery service electronic patient record system is consistently used to a high standard and captures any safeguarding concerns which link through to a dedicated safeguarding tab. This enables practitioners to quickly identify where there are safeguarding concerns with a child and store details of other key professionals, such as social worker and health practitioners. This good practice promotes multiagency working and ensures that relevant information is shared.

4. Looked after children

4.1 There is poor management, co-ordination and oversight of information and data regarding looked after children held by Solent NHS Trust. Information about looked after children placed out of area and waiting times and lists for both initial and review health assessments was not easily identifiable. This is recognised as an area for improvement and the team are developing processes to address this, however, the impact of this work was not evident at the time of this review.

4.2 Data supplied by Solent NHS Trust demonstrates variable completion in the timeliness of initial and review looked after children's health assessments. As a consequence not all children and young people who are looked after benefit from having their health needs assessed in a timely manner. (**Recommendation 4.6**)

4.3 Arrangements in obtaining consent for health assessments are not sufficiently well developed with an over reliance on the looked after children's health team obtaining consent. Solent NHS Trust obtains consent for the physical examination but this does not extend to the gathering and sharing of information unless someone with parental responsibility is present at the medical, allowing full consent to be obtained. This means looked after children who attend without someone with parental responsibility may not have a comprehensive initial health assessment which can delay their access to other health services. (**Recommendation 4.5**)

4.4 The most vulnerable looked after children are those placed out of area and we are not assured that this cohort benefit from access to timely and comprehensive health reviews. The looked after children's health team could not reliably identify this cohort and reported they often experience delays in having their health assessments completed. (**Recommendation 4.6**)

4.5 Children and young people who are placed out of area are now benefitting from scrutiny of their health assessments and plans. The designated nurse for looked after children now quality assures all reviews and plans to ensure they meet Portsmouth's quality standards and that they are "fit for purpose" before authorising payment. This provides assurance that vulnerable children placed out of Portsmouth are having a thorough assessment of their needs.

4.6 We saw evidence of some good initial and review health assessments and health plans, however, the overall quality is too variable. Health plans are not always SMART and therefore not all children and young people benefit from focussed plans which drive forward improvement in their health care. In some review health assessments we saw a lack of input from GPs, and SDQs were not always utilised fully during the assessments. (**Recommendation 4.7**)

4.7 It is positive that practitioners are increasingly exploring risk taking behaviours as part of initial and review health assessments. However, these assessments, are not consistently informed by a formal CSE risk assessment and this is a missed opportunity to systematically assess and identify CSE, especially as research shows us that this cohort of children are particularly vulnerable to exploitation. (**Recommendation 4.7**)

4.8 GPs, health visitors and school nurses receive copies of looked after child's health care plans which means that they are able to consider the content alongside any consultations that they have with the child or their carer. Children who are looked after are part of the 0-19 enhanced case load which means that their care is prioritised.

4.9 The looked after children's health team do not monitor the implementation of the health action plans. We acknowledge that this is the overall responsibility of the child's social worker, however, this lack of ongoing involvement and accountability will result in review health assessments being viewed as episodic rather than a continuum of care.

4.10 Portsmouth has a significant number of unaccompanied asylum seeking children. There is recognition in health and social care that the experiences of children and young people who are seeking asylum can have a profound and long-term impact on their health and wellbeing. Health assessments seen for this cohort on the whole met their needs, though practitioners undertaking this work have not received any formal specialist training.

4.11 Children and young people who are looked after and their carers benefit from access to a dedicated CAMHS team where they are prioritised and are able to access services quickly. The looked after children CAMHS service provide mental health assessments, direct work with children and young people, including foster carers, and are actively involved in range of multiagency meetings to support the child or young person. This means that support can be accessed in a timely manner by a specialist team who understand the increased vulnerabilities and complexities of a child who is in care.

4.12 Looked after young people who continue to need support from adult mental health services when they are 18 benefit from a well co-ordinated transition. The looked after children's CAMHS service are proactive in their approach to transition and offer a drop in for care leavers alongside adult mental health services. Practitioners are sensitive to the needs of the young people and support is offered in locations such as children's homes and hostels where a number of looked after young people and care leavers are placed.

4.13 Unaccompanied asylum seeking children who are identified as needing support from the looked after children's CAMHS team are not able to access the service until they have experienced a period of stability in placement, education and emotional care. Although their carers can access CAMHS team for advice and consultation at any time, this approach risks delaying access to specialist or therapeutic services. We were not made aware of any audit to demonstrate the impact or effectiveness of this policy.

4.14 The looked after children's health team raised to Portsmouth CCG that there were a number of unaccompanied asylum seeking children who were not registered with a GP. Portsmouth CCG and the local authority identified that whilst GP practices accepted these individuals, they were not being supported by their carers and social workers to access the GP service. Portsmouth CCG and the local authority worked together in an attempt to improve access to health services for unaccompanied asylum seeking children by providing a letter to support registration with primary care. Whilst there has been no audit or evaluation of the initiative's effectiveness the local area has assured us that all unaccompanied asylum seeking children are currently registered with a GP.

4.15 Young people leaving care receive a pack that contains relevant and personal health information to support their adulthood journey. However, the looked after children's health team recognise that there is potential to further improve this and are exploring opportunities, for example within primary care, to strengthen the offer.

5. Management

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

5.1 Leadership and management

5.1.1 Portsmouth LSCB identified the need to strengthen the reporting arrangements by health partners and are setting up a formal health sub group. Membership has been agreed and will include NHS commissioned provider services as well as the named GP.

5.1.2 The local authority and its partner agencies are using outcomes from national inspections to benchmark safeguarding arrangements across the local area. Examples include JTAI deep dive topics and as a result, priority is being given to reviewing the local response to domestic abuse and to neglect. As part of this work, the partnership has begun to explore the engagement of dental practitioners in safeguarding arrangements, although this is at a very early stage.

5.1.3 Portsmouth City Council, Portsmouth Public Health and Solent NHS trust have committed to an ambitious remodelling of services, 'Stronger Futures', combining health and care teams within MATs to increase the care provided in the community, with a clear focus on early intervention and prevention. This transformation of the early help provision has been subject of a phased implementation since April 2017 with a projected completion date of October 2017. The programme is currently on trajectory to meet its deliverables and this indicates the considerable commitment to the remodelling of the offer by the Portsmouth City Council and Solent NHS Trust NHS trust.

5.1.4 Governance arrangements within PHT trust are not sufficiently robust to ensure that the trust board can be assured on safeguarding practice across the organisation. The named and specialist health professionals in PHT have a significant improvement agenda however we are not assured that there is sufficient capacity in the PHT safeguarding team to address the deficits and lead the necessary improvements. Our concerns are compounded by the absence of a clear workplan with measurable objectives which would help to identify resource, support effective prioritisation and monitor progress. (**Recommendation 1.7**)

5.1.5 Data collection and reporting within the PHT is underdeveloped. The named professionals do not have access to any reports to enable them to identify patterns in referrals from departments across the organisation. The trust's IT system is not supporting effective safeguarding practice. We have shared our concerns surrounding the incorrect completion and bypassing of a 'mandatory' safeguarding screen and the timeliness and quality of information shared with community health services. Other examples include, incorrectly selected multiple choice safeguarding statements generated from the mandatory safeguarding screen which are pulled through to subsequent discharge documentation which could give false assurance to other practitioners in relation to risk.

5.1.6 Resourcing of the named professionals within Solent NHS Trust is not compliant with the RCPH Intercollegiate Guidance (2015). (**Recommendation 4.8**)

5.1.7 The named GP does not have sufficient resource allocated to fulfil all the responsibilities of the role as identified in the RCPH Intercollegiate Guidance 2014. The current postholder has one weekly programmed activity for children's safeguarding. Opportunities to develop this role further are hindered by the current resources allocated to the role. (**Recommendation 5.1**)

5.1.8 We have seen positive and effective safeguarding practice in primary care, however, this is not consistent across all GPs in Portsmouth. Where we saw good practice, flags on patient records clearly indicated vulnerability and information sharing was effective with all practitioners taking responsibility for safeguarding children.

5.1.9 The CCG identified and raised to the parenting board that there is a conflict of interest and lack of independence in oversight between the strategic and operational responsibilities of the shared designated and named doctor for looked after children. The CCG and Solent NHS Trust have acknowledged the need to resolve this. (**Recommendation 2.2**)

5.1.10 It is positive to note that the looked after children's designated and named nurses are members of the corporate parenting board.

5.1.11 The named nurse for looked after children provide quarterly performance reports to commissioners and trust safeguarding lead. However, the annual report regarding looked after children is not yet available to consider as part of this review. Given the findings identified in this report we are not assured there is robust scrutiny and professional challenge from the trust board and the CCG which should drive forward improved provision and health outcomes for all looked after children.

5.1.12 In the absence of a substantive named midwife postholder at PHT, informal arrangements are in place with the named nurse providing the strategic input alongside the safeguarding midwife who is providing support operationally. We were given assurance that the post has been advertised and interviews are due to be held imminently.

5.1.13 In line with this inspection's findings detailed earlier, the recent audit completed in maternity appropriately identified the need to improve midwives routine enquiry of domestic abuse and the recording of this. The resultant action plan is SMART but the impact is limited at this stage given the findings of this review. The plan rightly prioritises the need to make this important enquiry but could be strengthened further by asking throughout the women's care; the offer of a women only appointment; or completion of risk assessments for those women giving a positive response. (**Recommendation 1.7**)

5.1.14 The 0-19 service is currently undergoing workforce remodelling to ensure the Stronger Futures initiative is properly resourced although the impact of this is not yet realised. Although school age children benefit from the national child measurement programme (NCMP) at entry to and exit from primary school, it is evident that the need to carry out safeguarding work within the current resource has affected the capacity of the service to deliver other programmed work. Competing priorities has also impacted on the delivery of more preventative work and the absence of drop-in sessions in schools is a missed opportunity to identify vulnerable children via these opportunistic contacts. ***This issue has been brought to the attention of the local authority public health team.***

5.1.15 In reviewing the 0-19 services it became apparent that there is an unintended consequence on current practice of the local advice line operated by the MASH. Health practitioners can contact the MASH to seek advice on individual cases without revealing the name of the child or family concerned, this means that there is no record of the discussion or decision reached within children's social care. Whilst most health practitioners were making an entry in the health record of the discussion, we are concerned that important key information is not being recorded which may assist decision making by the MASH in future referrals where different practitioners express concerns about the same case.

5.1.16 There are well established strategic and operational multi-agency CSE arrangements in place in Portsmouth and partner agencies report that these are working effectively; making good use of hard and soft intelligence to identify "hot spots where young people may be vulnerable." A recent peer review of Portsmouth CSE arrangements by another local authority has been undertaken which has been helpful to local partners in taking this work forward. A shortened CSE assessment tool has been introduced across Portsmouth, however our review highlights that the use of this is not routinely embedded across all services which young people are likely to engage with, including school nursing, midwifery and primary care. The integrated sexual health service have a full risk assessment tool based on 'spotting the signs' however in records sampled it was evident that this was not always used where appropriate.

5.1.17 Positive action has been taken by commissioners and providers of services to meet the substantial increase in referrals to CAMHS. Local initiatives included the delivery of group work on anxiety and providing training on interventions for parents and workers. There has been a reduction in waiting times and positive feedback from those adults who have been involved in the training in supporting a child with emotional needs who reported that their skills and confidence in managing these issues had increased.

5.1.18 It is encouraging that PHT has met the national requirement in relation to child protection information sharing (CPIS) and the system is embedded. This is evidence of good local partnership working and a commitment to identifying vulnerable children and young people.

5.2 Governance

5.2.1 Record keeping arrangements in maternity are fragmented which prevents access to a complete record of women's care to include safeguarding information. Records kept by community midwives in community clinics are not accessible out of hours. Flags and alerts held on maternity electronic records are not visible to emergency department staff should the woman attend. As a consequence should women present to the maternity or the emergency department there is a risk that changes to the needs of women and the unborn whether escalating or de-escalating may not be known. (**Recommendation 1.8**)

5.2.2 The quality of referrals to children's social care by the maternity service are of variable. Stronger referrals identified good articulation of risks and protective factors to the unborn or child but this good practice was not consistent in all records seen. In the absence of any robust quality assurance arrangements it is not clear how good practice is acknowledged and weak practice is sensitively challenged and improved. (**Recommendation 1.9**)

5.2.3 Reports completed by midwives for initial child protection conferences do not benefit from a robust quality assurance arrangement. Some reports lacked sufficient detail and professional analysis of risks to the unborn and in one case did not align with the advice given by the safeguarding team. In the absence of any operational management or safeguarding team oversight it is not clear how this standard will be improved to achieve consistent practice that safeguards those in their care. (**Recommendation 1.9**)

5.2.4 The completed section 11 audits by PHT and also GP surgeries visited regarding frontline and governance of safeguarding practice do not reflect the findings of our review. Responses given by partners were generally either 'outstanding' or 'good' but often this this was not supported by evidence or any rationale for their finding. In particular due to the absence of fully embedded risk assessments around domestic abuse, partner's presentation and child sexual exploitation identified in midwifery services it is not clear how a rating of outstanding was achieved.

5.2.5 It is of concern that the current arrangements to upload key child protection documentation onto the 0-19 health records are ineffective. Delays in administrative processes within the business support unit and inconsistent processes, where some hard copies of documents and letters from other agencies were held in hard copy in files in cabinets, means that the electronic patient record is incomplete and important information is not always available to support decision making and inform patient care. (**Recommendation 4.9**)

5.2.6 There is an effective system for assuring the quality of the contribution of health visitors and school nurses to child protection conferences and of the content and detail in early help assessments. This was evident in every case we looked at in the 0-19 service where good detail in factual information, the level of analysis and the setting of generally SMART objectives was of a high standard. The effective application of the restorative approach by practitioners in this service is leading to delivery of relevant and meaningful change in the outcomes for children.

5.2.7 Records in integrated sexual health service did not contain copies of referrals or reports submitted to children's social care which means the patient record is incomplete. As a consequence we could not review the quality of this important safeguarding practice. In the absence of any formal quality assurance of referrals we cannot see how the trust are assured on safeguarding practice within this service. (**Recommendation 4.10**)

5.2.8 The paediatric liaison sister at QAH, as part of her safeguarding role, has recently begun to meet the practitioner to review findings of her weekly audit and these meetings are recorded with a view to contributing to the quarterly safeguarding reports made by the PHT named nurse to the safeguarding committee. However, the record of this meeting that we saw, did not include discussion of the quality of referrals that have been reviewed and any remedial or developmental activity undertaken with individual practitioners to ensure continuous improvement. (**Recommendation 1.7**)

5.2.9 Progress is being made to improve understanding of work practices and information sharing between the Children's ED and community paediatric services. Regular meetings are taking place, with a recent focus on increasing compliance with the LSCB bruising policy.

5.2.10 Adult ED practitioners making entries into the electronic patient record system, are identifiable for the most part only by name rather than by role. It is considered good practice to include this level of detail to ensure robust professional accountability.

5.2.11 The named doctor was not able to give assurance that the peer review process which takes place on a 6 monthly basis is compliant with Royal College guidance. The approach reported does not align with Royal College of Paediatric and Child Health guidance. The named doctor has a planned meeting with the community paediatricians who undertake monthly peer review in order to inform the revision and strengthening of the PHT peer review model.

5.2.12 CAMHS practitioners are not always able to access the patient record during consultations. CAMHS practitioners reported significant delays in access the electronic patient record system at 'peak' times. Not being able to access clients records, especially for duty workers in SPA team presents concerns for effective safeguarding practice. (**Recommendation 4.9**)

5.2.13 There is inconsistency in how adult mental health services are identifying and flagging children and vulnerability in adult health records. Records reviewed highlighted variation in where the details of children were recorded. On most cases seen, children's names and dates of birth were in free text in the "risk" section instead of in fields within the clients demographic details which would ensure the details of the children are drawn through the record. The presence of children was not always immediately clear on opening the record and there was poor use of the alert facility on the electronic patient record system. Some records did not have an alert even though there were children known to be at risk or where there was known to be a potential risk to staff when visiting a client. Effective use of alert systems are an essential component of robust risk assessment and can be vital in ensuring the safety of staff and clients. (**Recommendation 4.9**)

5.2.14 Safeguarding referrals from adult mental health and Recovery practitioners are quality assured by service and team managers prior to them being submitted. Records seen contained clear analysis of risk and protective factors to help inform decision-making in the MASH.

5.2.15 On the whole records seen demonstrated good liaison between health services. Sharing of information was facilitated by easy access to other health agency's records via a shared electronic patient record system which is used by all but one GP practice in Portsmouth. A visit to this GP practice indicated that despite a lack of information sharing protocols it was found that information sharing between this practice and the community health teams about vulnerable children and families is generally effective.

5.2.16 We have seen evidence of very recent improvement in the recording and utilisation of risk assessments within adult substance misuse. Practitioners are starting to utilise the comprehensive risk assessment within the electronic record system more effectively and this is supporting better oversight of risk to children in families where adults misuse substances. However, this is a new initiative and we are aware that some service users have not had an updated risk assessment since 2015. Failure to appropriately update risk assessments means there is potential that significant changes to the risk that the adult service user poses to a child may go unreported and this is unacceptable. ***This issue has been brought to the attention of the local authority public health team.*** (**Recommendation 6.1**)

5.2.17 There are no internal formal quality assurance arrangements of initial and review health assessment completed for children and young people who are looked after. External audits by NHS Wessex of initials, reviews and OOA health assessments have been achieved. Random sampling undertaken by named doctor to oversee standard of practice is in place but this is ad-hoc. This approach to quality assurance limits the opportunity to highlight good practice and improve weaker standards. (**Recommendation 4.7**)

5.2.18 Looked after children health professionals recognise that there are areas for improvement and are seeking ways to address known gaps. Standard operating procedures were reported to be in development to support consistency and improvement but these were not available to review. The pace to support improvement was not well evidenced during this review. This has been challenging though as the named nurse for looked after children has only been in post since April 2017 and the named and designated doctor for looked after children has been off work for a period of time.

5.3 Training and supervision

5.3.1 The MASH health navigator has appropriate child safeguarding and paediatric nursing experience and has appropriately undertaken level 4 safeguarding training. She reports feeling well supported in her role with access to training and development opportunities and receiving monthly supervision from the associate designated nurse alternating with the MASH service manager.

5.3.2 Compliance with safeguarding training within PHT is reported as improving though rates within maternity do not currently meet either CQC or local KPIs. Level 3 training remains single agency as the trust has found it difficult to release staff to attend the PSCB two day multi-agency training. The trust named nurse reports that she is planning to work with the PSCB in developing level 3 topic-based short workshops and sessions to ensure that PHT staff needing level 3 training are able to access a multi-agency component to this in line with best practice. If practitioners are not able to access training this limits their ability to identify safeguarding risks and respond effectively to protect those in their care.

5.3.3 Newly qualified midwives have access to support and band seven staff are available to support their developing practice. However, newly qualified midwives do not benefit from a more structured and formal approach to developing their competence around safeguarding as part of their preceptorship. This is a gap and a missed opportunity to effectively standardise best practice in protecting children across the service. (**Recommendation 1.10**)

5.3.4 Maternity staff have not all received any dedicated training about caring for the mental health needs of women. This is particularly pertinent for those women that experience crisis given the reported challenge in accessing specialist psychiatric care for women that are mentally unwell on the ward. (**Recommendation 1.4**)

5.3.5 Within PHT all community band seven midwives are trained to provide supervision. Audit data from May 2017 indicates that safeguarding supervision is not well established and we were unable to locate any evidence of supervision on patient records. Regular supervision is an integral part of a practitioner's development and supports effective safeguarding practice. (**Recommendation 1.11**)

5.3.6 Group supervision is in place for the paediatric specialist nurses, including the paediatric diabetes specialist nursing team, and also other staff groups who have regular contact with children. However, supervision arrangements across the ED department remain underdeveloped and staff are not benefiting from regular opportunities for support, reflection and constructive challenge to practice. (**Recommendation 1.11**)

5.3.7 The safeguarding supervision model in use in the 0-19 service is effective and is research based. This enables managers to understand practitioner's case-loads and ensure equitable allocation of work. It also allows more complex cases to be identified when additional supervision may be offered. Practitioners also access monthly group safeguarding supervision where individual cases are discussed among peers and any learning is distilled and shared. Supervision discussions are guided by a templated format, and were seen documented on patient records using the same format, that considers the child's situation, risks, protective factors and planned actions. This ensures there is a clear rationale for any decisions or actions derived from the supervision.

5.3.8 Compliance with Level 3 safeguarding training in the 0-19 service is good. All practitioners receive safeguarding training that meets the appropriate level of the relevant guidance for specialist staff. Although this training is delivered primarily through the trust's single agency safeguarding training programme, practitioners also have access to the PSCBs multi-agency training events. Data supplied by the provider indicates that all of the 0-19 staff are up to date with this training except for those small number of staff who are long-term absent.

5.3.9 Integrated sexual health service team have access to safeguarding supervision in a range of formats such as part of a six weekly education day or as ad-hoc with a safeguarding lead if required. We saw evidence of facilitated case discussion and sensitive professional challenge with appropriate actions evident. All staff have accessed one half day training for peer and safeguarding supervision.

5.3.10 PHT have been proactive in taking the initiative to train their health practitioners who are likely to care for children and young people who are looked after on the particular complex needs and vulnerability of this cohort of children. Professionals reported that the event went well and although it is too recent to evaluate the impact of the training, there are plans to repeat the event annually to ensure looked-after children retain a high profile in ED.

5.3.11 There is a good offer from the looked after children's CAMHS and looked after children's health team to foster carers. The looked after children's CAMHS service provides consultation and training to professionals and foster carers giving opportunities to reflect and better understand the needs and behaviours of the young person. They promote the most appropriate approaches to helping them manage the child's distress and to enable them to feel safe and offer telephone support where required. The looked after children's health team offer training and support to foster carers around the initial and review health assessment processes as well as the health needs of children and young people who are looked after.

5.3.12 CAMHS offer effective consultation, supervision and training to a number of multiagency partners, upskilling them in face to face work with children and young people. Barnardos workers and CAMHS have good access into children's homes, hostels, school and other key partners around the city, supporting practitioners working with vulnerable children helping with recognition of risks to the young person, and offering insight into their emotional and mental wellbeing, as well as developing strategies to help keep them safe.

5.3.13 Safeguarding supervision arrangements within CAMHS service have recently been strengthened. Each member of staff within CAMHS now has regular clinical and managerial 1:1 supervision which routinely includes a focus on safeguarding and discussion about the action plan and what needs to happen to keep the child or young person safe.

5.3.14 Solent NHS Trust safeguarding team has recently introduced group safeguarding supervision to adult mental health multi-disciplinary staff including the in-patient unit on a monthly basis. This is a positive development facilitating reflective practice as case examples are discussed. A complex case study review has also been recently facilitated in the adult mental health multi-disciplinary team. The service found this multi-disciplinary case analysis useful and there are plans to hold a similar event. This is helping to support continuous improvement in safeguarding practice in Solent NHS Trust adult mental health.

5.3.15 Managers in adult mental health provide monthly 1:1 supervision to practitioners and all case discussions include a focus on safeguarding and whether the practitioner is appropriately identifying concerns. However, managers have not undertaken any safeguarding supervision training to facilitate and support staff as is best practice.

5.3.16 Safeguarding training within adult mental health services is not sufficiently equipping practitioners with the skills to identify and assess risk so that the hidden child is adequately protected. Adult mental health practitioners undertake level 2 safeguarding training, with service managers undertaking level 3, this is not compliant with the Intercollegiate Guidance. (**Recommendation 4.11**)

5.3.17 Adult mental health practitioners interviewed were not aware of the new model of child protection case conferences being introduced by children's social care and have not undertaken any training. We are aware that the manager of the adult mental health A2I service is working with the MASH to roll out joint training for adult mental health and children's social care practitioners.

5.3.18 Similarly training within the adult Recovery service is not compliant with the intercollegiate guidance, however records seen showed evidence of effective safeguarding practice. Managers provide regular one to one supervision which includes case discussion utilising a comprehensive safeguarding matrix which pulls data from the electronic record system to provide assurance on a number of risk factors relating to clients and any linked children. Safeguarding discussions were evident in records seen, including the plan of action to minimise risk factors highlighted. However, as managers are not undertaking safeguarding training at an appropriate level, this does not equip them to oversee highly complex safeguarding work effectively. (**Recommendation 4.11**)

5.3.19 Looked after children professionals have access to a range of training to support compliance with inter-collegiate guidance. Nursing staff have access to looked after children supervision and the named nurse has access to regular supervision from the designated nurse. Community paediatricians have regular management supervision but peer, case supervision is not formalised and is completed under an ad-hoc approach which does not fully align with best practice guidance set out by the Royal College of Paediatrics and Child Health.

5.3.20 Training for looked after children staff about needs of unaccompanied asylum seeking children does not appear well developed. The designated doctor has undertaken some informal training, however, we did not see implementation of tailored, evidenced based assessment of health need when sampling initial health assessments, reviews or in general health records when an unaccompanied asylum seeking child accessed health services.

5.3.21 Primary care staff access a range of training to support their compliance with safeguarding requirements. This includes online, face to face with safeguarding leads and TARGET training with input regularly to this by the named GP. Practices visited used locums from one agency that gave assurance that staff met requirements for safeguarding children. The named GP reported being well supported by designated professionals in undertaking their role.

Recommendations

1. **Portsmouth Hospitals NHS Trust should:**

- 1.1 Ensure that all expectant women receive a comprehensive assessment of risk and vulnerability, to include exploration of domestic abuse, mental health, partner behaviour and exploitation and that appropriate advice, support and care is made available to them through a co-ordinated package of support.
- 1.2 Improve the identification, assessment and recording of risk to children of adults who attend ED with concerning behaviours.
- 1.3 Ensure that all children who attend the children's ED have a comprehensive risk assessment to ensure that they are safeguarded appropriately and that all practitioners are compliant with the trust's policy and processes.
- 1.4 Ensure that expectant women with mental ill health or learning disability are cared for by practitioners who are trained to meet their needs.
- 1.5 Ensure that unborn and newborn babies are protected effectively and evidence compliance with the LSCB Unborn and Newborn Baby Safeguarding Protocol.
- 1.6 Improve the content of the GP summary report following attendance at ED to include any safeguarding concerns or risk to a child or young person.
- 1.7 Improve the safeguarding and governance arrangements throughout the trust so that the trust board is able to be assured of effective safeguarding practice throughout the organisation.
- 1.8 Improve record keeping arrangements within midwifery services so that practitioners have access to a complete record.
- 1.9 Improve the quality of child protection referrals and reports within midwifery services so that they are of a consistently high standard and support the identification and ongoing assessment of risk to the unborn and newborn infant.
- 1.10 Ensure that newly qualified midwives demonstrate competency in child protection practice as part of their preceptorship.
- 1.11 Ensure that all staff who work with children who may be vulnerable or be supported through a child protection or child in need plan are accessing safeguarding supervision in line with trust policy.

2. Portsmouth CCG should:

- 2.1 Support primary care in the introduction, implementation and evaluation of the local risk assessment tool for CSE in young people so that victims may be identified and supported at the earliest opportunity.
- 2.2 Ensure the arrangements and job descriptions for the designated and named doctor for looked after children are compliant with the intercollegiate guidance and that there are clear accountability arrangements for the strategic and operational responsibilities for each postholder.

3. Portsmouth CCG, Portsmouth Hospitals NHS Trust and Solent NHS Trust should:

- 3.1 Ensure that expectant women or post natal women who are cared for as an in-patient on the midwifery wards and have an acute mental health crisis can access adult mental health services following an agreed care pathway.
- 3.2 Ensure that children and young people who are suffering from mental ill health or have self harmed and are admitted to the acute paediatric ward are appropriately safeguarded through thorough risk assessments and cared for by practitioners who have received training in mental health illness in this age group.
- 3.3 Agree and implement a care pathway to support young people between 16-18 years who attend ED with mental ill health or self harm to ensure that their mental health and physical care needs are met and that they are safeguarded effectively.
- 3.4 Ensure that the local MARAC arrangements are fully inclusive of all partners, including primary care.
- 3.5 Improve paediatric liaison arrangements between the ED and the 0-19 service by ensuring that concerns are being appropriately identified and that there is timely sharing of attendance by children or young people to support effective intervention.

4. Solent NHS Trust should:

- 4.1 Work with partners to ensure effective implementation of the LSCB escalation policy to address areas of professional disagreement.
- 4.2 Improve the identification, assessment and recording of risk to children and young people within the integrated sexual health service.
- 4.3 Improve the identification, assessment and recording of risk around CSE within the 0-19 service.

- 4.4 Ensure that all practitioners who are working with families where there are adults with mental ill health and vulnerable children share information appropriately, including adult mental health recovery and crises plans.
- 4.5 Work with partners to improve the arrangements for initial and review health assessments to ensure that appropriate consent is obtained at the earliest opportunity to minimise delay in carrying out assessments for looked after children.
- 4.6 Improve the collection of data to inform timely planning of health assessments for children and young people who are looked after, including those children placed out of Portsmouth local area.
- 4.7 Ensure that all looked after children receive high quality health assessments that are informed by robust assessment of risk, including scores from SDQs and information from GPs and that these reviews are informing SMART health care plans that are improving health outcomes.
- 4.8 Review the capacity of the named professionals to ensure compliance with RCPH Intercollegiate Guidance 2015.
- 4.9 Ensure that patients' electronic records are a complete record of their care, contain flags to highlight vulnerability and risk, contain all key documentation and are accessible during patient consultation.
- 4.10 Improve arrangements for record keeping and quality assurance within the integrated sexual health service.
- 4.11 Ensure that the training needs analysis for adult mental health services is compliant with the RCPH Intercollegiate Guidance 2015 and local LSCB policy and that adult mental health staff access training according to guidance.

5. Society of St James and Solent NHS Trust should:

- 5.1 Ensure all service users have current risk assessments recorded on their client record and that any safeguarding risks have been identified and escalated.
- 5.2 Ensure that the training needs analysis for the adult recovery service is compliant with the RCPH Intercollegiate Guidance 2015 and local LSCB policy and that recovery staff access training according to guidance.

Next steps

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

Please submit your action plan to CQC through 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.