Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in West Sussex

Date of Inspection	**8 -19 November 2010**
Date of final Report	**21 January 2011**
Commissioning PCT	**NHS West Sussex (5P6)**
CQC Inspector name	**Lynne Lord/Sue Eardley**
Provider Services Included:	**Western Sussex Hospitals NHS Trust (RYR) - Location - St Richards Hospital (RYR16) Queen Victoria Hospital NHS FT (RPC) Sussex Partnership NHS FT (RX2)**
CQC Region	**South East**
CQC Regional Director	**Roxy Boyce**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.

West Sussex	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Inadequate
Capacity for improvement	Inadequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's head of national Inspections, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context

Commissioning and planning of national health services and primary care are carried out by NHS West Sussex. Universal children's services, such as health visiting, school nursing, looked after children nurses and paediatric therapies, are delivered by Sussex Community NHS Trust (SCT), which was formed on 1 October 2010. The main providers of acute hospital services are: Western Sussex Hospitals NHS Trust

(St Richard's in Chichester, Southlands in Shoreham-by-Sea and Worthing Hospital); Surrey and Sussex Healthcare NHS Trust, and Brighton and Sussex University Hospital NHS Trust (Royal Sussex in Brighton and Princess Royal in Haywards Heath). Queen Victoria Hospital NHS Foundation Trust provides community services in East Grinstead and specialist reconstructive surgery. Child and adolescent mental health services (CAMHS) are provided by Sussex Partnership NHS Foundation Trust through separate contracts from the county council and NHS West Sussex. There are 182,000 Children and Young People in West Sussex with a child health budget of £98m. There are 167 children and young people placed out of county with 80 in residential or maintained accommodation.

1 General – leadership and management

1.1 Service agreement specifications for commissioned health services routinely include reference to safeguarding children although more detail is required in contracts to set out exactly what is within the scope. Across the Primary Care Trust, Acute and Mental Health Trusts, a clear safeguarding strategy is supported by policies and guidelines which reflect the guidance in 'Working Together to Safeguard Children' 2010. Policies and procedures for child protection and safeguarding are well understood by healthcare staff and there is a strong safeguarding ethos.

1.2 A Pan-Sussex policy is to be implemented by the end of 2010 to ensure that healthcare has complete standardisation of safeguarding guidance. Support and guidance are promoted through the designated and named nurses and doctors for safeguarding, including GPs and midwives. A new post of head of safeguarding for adults and children, created in the Commissioning PCT in February 2010, has resulted in improved monitoring and oversight of practice. There is appropriate representation from healthcare on the LSCB, with senior executive leads from both the Primary Care Trust and Acute services attending.

1.3 Overall PCT oversight of safeguarding is very good with clear performance monitoring and reporting arrangements and since February there has been increased maturity of management and political acumen to developing a robust safeguarding structure across the commissioned services. There had been no formal PCT annual safeguarding report; this is expected in March/April 2011.

1.4 The PCT Board is informed by two formal subcommittees which review safeguarding issues, the Audit and Assurance Committee and the Quality Innovation, Learning ad Leadership Committee, which are in turn informed by the Quality Management, Risk and HIS Risk & Audit Committees. Each group (QuILL and QM) has a clear "charter" that includes objectives deliverables and milestones.

1.5 An NHS Professionals Safeguarding Children group (a subgroup of the LSCB) meets quarterly and provides operational oversight, monitoring progress against the work plan through a traffic-light rating system

1.6 A major commissioner-led review of community services is in progress, triggered by the merger in October, to include paediatrics, Child Development Centres and safeguarding, fed by other reviews such as teenage pregnancy and the pan-Sussex review of safeguarding nurse support arrangements. Some staff expressed

uncertainty and concern that risks and benefits are not being acknowledged. The SALT service has already been reviewed and staff are more confident as a result that the service is focussing on outcomes and quality although the implications on practice of change may be underestimated. The previous merger of five PCTs to one for West Sussex is still being worked through and there is some inconsistency of practice across the areas as a result.

1.7 The PCT conducts "deep dive" reviews through the QUILL group. A review of child safeguarding took place in July with 3 lay people on the panel to provide challenge. There are thorough governance reviews of providers (one a month) using the Monitor toolkit, and the Quality Management Committee conducts a bimonthly review of SCR actions with clear progress being made. .

1.8 Budgets are pooled for some services and there is a strong commissioning partnership, based on gaps and issues on the JSNA such as SALT, CAMHs and emotional well-being as well as areas advised through engagement such as housing. Planning is generally carried out jointly but has been challenging to achieve; work streams are action focussed with identified leads and there is a Memorandum of Understanding with a S75 agreement scheduled for April 2011. Inclusion of the Healthy Child programme for universal services and the urgent care pathway programme will take place next year.

1.9 Outcome monitoring for the work streams is at an early stage but the SALT project, for example has reduced waits from over a year to under 18 weeks with improved identification, local intervention and appropriate referrals. There is good engagement across the partnership with joint commissioning, including workshops for GPs and good public health information.

1.10 The Acute Hospitals have recently undergone a merger of the two main hospital sites in Chichester and Worthing becoming the West Sussex NHS Trust (RYR). The transition has been well managed and has resulted in a programme of harmonisation of policies and guidance. The trust has a strong safeguarding ethos, well embedded into clinical practice. There is an effective safeguarding team and staff feel confident in the trust processes and the support they receive.

1.11 There is evidence of safeguarding requirements being met within the Sussex Partnership NHS FT (RXR) who provide the Children's and Adolescent Mental Health Services (CAMHS) services across the county. Named leads for both medical and nursing ensure that staff are supported appropriately and comprehensive policy documentation is in place for safeguarding and for transition into adult services.

1.12 There is considerable enthusiasm amongst GPs to grasp the White paper opportunities with a "Southern Coast Federation" of 5 localities, intending to form a shadow commissioning group from 1st April 2011. Similarly in the North three localities have come together. The PCT is facilitating these developments and working closely to ensure that safeguarding children issues are addressed and sufficient and appropriate governance arrangements are in place, with a gradual rollout of responsibility for Quality.

2 Outcome 1 Involving Users

2.1 Workshops for young parents to be are held within colleges to provide advice on health and well-being issues, sexual health, careers, training and further education opportunities and to signpost to other agencies. Following feedback from young people, outreach sexual health teams are using touch screens when entering personal details and reason for attendance in clinic settings to improve confidentiality. Drop in health and well-being sessions for young people have been reorganised in some areas in response to their feedback. This has resulted in increasing access and capacity to sexual health advice, contraception and Chlamydia testing

2.2 Overall involvement of users by health partners across the community is adequate. There is a Young Mums and Partner Group in Worthing that has good engagement from young mums and increasingly their partners. Saturday and Sunday brunch clubs are also held in Lancing and Chichester for dads of all age ranges and it is reported that although attendance can vary, this is a good forum to gain user views and to act on any suggestions for improving areas of practice.

2.3 There is an awareness of the "You're Welcome" criteria but no unit has been accredited yet and involvement of YP in respect of safeguarding is underdeveloped.

2.4 Equality and diversity are adequately addressed. Key issues are being identified and responded to. An example is the access for some parents from Gypsy and Traveller sites to health services and to immunisation which has led to the development of alternative routes to services.

2.5 It was widely reported across health groups that appropriate regard is given to Children and Young People's ethnic and cultural needs when undertaking any care or risk assessment. Interpreters are utilised, with no issues of availability whenever required. For example mental health support to displaced families in the Gatwick area considers the needs of displaced children.

3 Outcome 2 Consent

3.1 The Acute Trust has appropriate policy and procedure guidance in place for staff, in regard to obtaining parental or carer consent for treatment and procedures prior to any surgical procedure for CYP. This reflects DOH guidance and takes into consideration Gillick Competency of the young person.

4 Outcome 4 Care and welfare of people who use services

4.1 The LAC team, based in SCT comprises 5.2 WTE Nurse Specialists, including 0.8 with specific responsibility for unaccompanied asylum seeking children (UASC). One nurse is allocated to each of the three fostering panels.

4.2 There is an effective health service for asylum-seeking children with a GP with a special interest and a specialist named nurse providing a monthly clinic in Haywards Heath, and all asylum seeking children have an initial health assessment within 28 days of becoming looked after. School nurses have good arrangements in place for

monitoring the health of LAC within their caseload, including colour coding of folders by need and clear healthcare plans which are reviewed regularly.

4.3 The PCT received its first annual report in June 2010 which sets out progress to date but could benefit from a strategic plan for improvement and involvement.

4.4 Services to ensure looked after children have healthy outcomes are adequate. All looked after children are registered with a GP. Statutory health checks are monitored effectively, with 90.6% of health assessments, 94% of dental checks and 97% of immunisations up to date, showing a marked year-on-year improvement and follow up to ensure that checks are completed. Initial health assessments are undertaken by paediatricians in the south and west of the county, while GPs undertake the assessments in the north. Many of the GP assessments are of poor quality; of the ten case files examined only one of these had assessments undertaken by a GP and this was satisfactory. All health assessments result in a health care plan which details identified health needs and appropriate referrals for health care. Assessments are shared with social workers and other key health workers. Delays in conducting initial health assessments within the statutory 28 days arise as a result of the late receipt of relevant information from social workers.

4.5 Contrary to statutory guidance, a designated doctor for looked after children has not yet been commissioned by the Primary Care Trust, although the role is currently covered by a paediatrician from the provider service. Dental care is good with a responsive service by local practitioners.

4.6 Within SCT (the community provider service), the looked after children's health team is effective and enthusiastic, with well developed relationships across providers and with the council. Information systems enable all looked after children placed in the county by the council and other authorities to be identified and for their health to be monitored, although poor notification by the council and other placing authorities poses a challenge in ensuring information is accurate and up to date.

4.7 The 130 children placed out of area do not yet have good support for healthcare in line with responsible commissioner guidance and it is not clear who makes decision for placement – the council does not consult the PCT.

4.8 Teenage pregnancy rates remain high, although there has been a concerted effort to address sexual health for looked after children and numbers have fallen in the last year. Chlamydia testing rates are low and school nurses are not commissioned to provide emergency contraception, even though many are trained to do so. An intensive support programme, delivered by midwives in children's centres and young people's homes, provides young parents with valued skills on a range of health and well-being topics.

4.9 A recent report on the Sexual Health Needs of LAC within West Sussex to the Teenage Pregnancy Board recommended a 6-month pilot project for a Care Leavers Nurse with an emphasis on sexual health and teenage pregnancy. This has not however been funded by the partnership, and healthcare for care leavers is poor.

4.10 Alcohol misuse is a significant problem in West Sussex with 12% of boys and 13% of girls reporting they regularly drink to get drunk. There is an integrated drop-in service, and care pathway through alcohol and hospital admission, but the focus is on all-age support, and drug misuse rather than alcohol. The drug and alcohol service has been commissioned with a new non-statutory provider and although the vision is for improved accessibility outcomes data is not available.

4.11 Children's and Adolescent Mental Health Services (CAMHS) across the county is provided by Sussex Partnership Trust (RX2). Access to CAMHS across the county is variable, with primary care staff reporting high thresholds and a service that focuses on adolescents with no service for pre-school children. Waiting times for treatment following referral are currently around four weeks. For young people with urgent needs assessed as high risk, the waiting time is usually no longer than two weeks. A rapid response referral pathway is also available through the crisis team which provides assessment for young people who present to accident and emergency services and enables access for young people into the substance misuse service. There is a good and increasingly accessible service to young carers and this has led to a significant increase in referrals. The service is highly valued by young carers who are able to access an appropriate range of services. Transition arrangements and liaison between children and adult services are appropriate, and jointly agreed protocols are in place with transition work commencing when the young person reaches around 16 or 17 years of age.

4.12 Tier 1 and 2 services are provided in the Targeted Mental Health service by Primary Mental Health workers based in schools, including the Pupil Referral Unit. Joint work is undertaken with school nurses and educational psychologists. There is also a specialist primary mental health post for Unaccompanied Asylum Seeking children, with funded sessions for 3 days per week although the individual is on maternity leave and the post is not covered.

4.13 A specialist mental health team for West Sussex looked after children comprises seven full time staff which streamlines referral allocation through a multi-agency panel and specialists in the team include cover for permanent fostering UASC, adoption, leaving care and a(new) complex behaviour service. The team work with some children placed in Independent fostering agencies but do not cover those West Sussex children placed out of area. Outcome measures for the team include effective use of the Strengths and Difficulties Questionnaire (SDQ), plus measuring efficacy in qualitative form, such as carer questionnaires. There is good liaison with the social care team, foster carers, and social workers to improve understanding of "jargon" and improve placement stability, as well as providing support to carers and young people should a placement break down.

4.14 It is reported that there are regular reviews undertaken with the LAC health team, however this was not reflected during case tracking.

4.15 There is a consultation telephone line available 12-1 on a daily basis to access immediate guidance and sign posting to the most appropriate service or to assist with a referral into CAMHS. This is well used by other health professionals and schools and has resulted in more appropriate referrals into tier 3 and 4.

4.16 Tier 3 and 4 interventions are provided in a 12 bedded unit at Chalkhill for YP 16-18 yrs. Staff have all undertaken level 2 or 3.Within the unit there is a special care room that can accommodate under 16yr olds , to avoid admission to the general children's ward.

4.17 The Leap Frog programme is a multi dimensional support programme that has just secured mainstream funding for the next three years. The programme provides an intensive care programme to support 2-6 yrs olds who are experiencing multi placement breakdown. Work is undertaken both with foster carers and natural birth families. Specialised family carers work closely with education coaches within a multidisciplinary team and have daily contact with the child. There are 6 children currently within the programme and overall to date the impact for these children has resulted in 2 almost on the cusp of returning to their birth family. Once this has been achieved and reviewed the programme can then apply for accreditation with the Institute of Psychiatrists.

4.18 Transition arrangements into adult mental health services are good. Jointly agreed protocols are in place and transition work commences when the young person reaches around 16 -17 yrs of age. This has resulted in good liaison and improved outcomes for YP.

4.19 There has been a significant improvement in SALT through effective commissioning and performance monitoring. The service links to early years and schools and waiting times have dropped from over a year to under 18 weeks, and the team works with the courts to identify understanding and communication needs of young offenders. Alerts are usually through health visitors and there is good training for parents and foster carers as well as support staff in schools and the wider workforce which is improving awareness and early referral. More complex needs are managed through the child development centre.

4.20 The community nursing team provides a skilled service but is extremely pressured with a caseload of around 500 including a high proportion of children with cancer. Changes to the service such as reduced support for schools around epilepsy and provision of medication are being introduced but there is some confusion as to the current arrangements.

4.21 Holly Lodge, is a respite home for disabled/life limited children owned and run by Sussex Community NHS Trust. Its aim is to reduce hospital admission by providing support to parents and there is always a children's nurse on site.

4.22 Pressure on the health visiting service means that whilst most of the universal healthy child programme is being delivered, antenatal visits do not always take place, and staff report that around 25% of their work is pure child protection work. Significant increases in child numbers in Crawley, up by 500 in the last year, are putting pressure on the service and recent negotiations with GPs about provision of health visiting have been concluded in the form of an action plan which was agreed jointly by the PCT, the then West Sussex Health and the local GP representative. This is monitored hrough the contract process.

4.23 Services for disabled children are provided from four child development centres and benefit from co-location and good interagency communication within health. However, engagement with the children's social care disability team is poor with referrals being rejected; health staff report that their concerns around neglect and early child in need support are ignored until a child protection incident occurs. Senior managers are beginning to tackle this issue working across teams to improve the quality of referrals and agree thresholds.

5 Outcome 6 Co-operating with others

5.1 The looked after children health team have developed a two-day training course for foster carers covering physical health and emotional well-being, which is highly valued. Effective liaison and regular visits to all children's homes and independent fostering agencies enable all looked after children to be identified. Support for carers and young people includes appropriate enuresis advice, sexual health and smoking cessation support

5.2 Links between social care teams, schools and clinicians for looked after children are generally positive where there has been better stability of social work staff. There is effective partnership work between the nursing team and children's homes within the county, with looked after children nurses visiting and providing assessments, heath and lifestyle advice and training and support for care staff. Links between health services and foster carers are good and a number of two-day training courses are provided by the health team together with fostering agencies.

5.3 Communication between front line health and social care teams ensures that all those who are looked after in the area are accounted for and their location and healthcare status are known by all relevant healthcare professionals. This enables, for example, prompt follow-up where a young person fails to engage with substance misuse services. However, poor notification of placements or placement changes made by the council and other placing authorities poses a challenge in ensuring information is accurate and up to date. Effective communication between the health team and independent reviewing officers ensures that where health partners have not been involved in cases, they are followed up.

5.4 Direct work by the health team for looked after children is good and is enhanced by effective services provided by sexual health, CAMHS and school nurses. Some communication difficulties arise when children and young people move placement and the looked after children health team is not made aware of the change quickly enough, which results in missed appointments. Since the recent reorganisation of social work teams, health professionals report a lack of understanding among some social workers of the importance of sharing background information with the health team in advance of looked after children health assessment, which results in some children and young people having delayed assessments. There has been poor uptake among social workers of training that has been offered by the health team. Overall, however, there is good liaison between looked after children health services and the social care teams, foster carers, and social workers to improve placement stability, as well as providing support to carers and young people should a placement breakdown.

5.5 There is currently good clinical liaison with LAC teams in other authorities for placement support in terms of health needs, although the commissioning arrangements are still being negotiated, and there are early signs of inequity developing as provider services, such as CAMHs become more restrictive on service provision. There is increasing evidence of schools maintaining contact with health teams, particularly around LAC, to support overall development and track those placed for outside the authority.

5.6 There is an integrated governance group within Sussex Partnership FT (RX2) which has membership from CAMHS, adult services, social services, specialist mental health workers and the Designated Nurse for safeguarding in the PCT.

5.7 Within CAMHS, the children and young people's planning forum has resulted in improved joint working across social care, health and schools. However CAMHs universal services are difficult to access and health visiting and school nursing staff indicated that referral thresholds are not clear and there is an extremely limited service for preschoolers and primary age children. Although the LAC CAMHs service is good, it can now only be accessed through social worker referral, and they will only see a child once the placement is stable.

5.8 CAMHs representatives rarely attend case conferences and strategy meetings and whilst written commentaries may be submitted there are concerns that the emotional and mental health needs of children and young people are not sufficiently considered in care planning.

5.9 Alcohol misuse amongst young people is a significant problem in West Sussex. An integrated drop-in service is in place with a care pathway for alcohol misuse and hospital admission, but the focus is on all-age support rather than targeted provision for young people, and on wider drug misuse rather than specifically tackling the problem of alcohol misuse.

5.10 Some multi-agency partnership projects across health care work well to provide early recognition and intervention that support children and their families. Within all clinical specialities, practice groups are multi-disciplinary and multi-agency. The designated nurse for the Primary Care Trust is chair of the West Sussex NHS Professional Safeguarding Forum, the professional advisor for the LSCB and the chair of the Board's quality and effectiveness group and the LSCB training group. The designated doctor also provides professional advice to the LSCB. This promotes communication and partnership working across healthcare.

5.11 A model of co-located team working "the Hub" was established in Littlehampton but proved unsustainable, taking resource from front line social care. Although now disbanded and the team dispersed it set a model of team working and aspiration around information sharing that continues across services.

5.12 The "team around the school" is working successfully in some areas, with mental health, school nurse, SALT and medical input to monthly meetings based in a secondary school and including feeder primaries. The healthy schools programme is under review as schools recognise the importance of health education but despite enthusiasm from school nurse team there is insufficient central support and focus on

sexual health services with poor chlamydia testing take-up and a lack of shared pathways to support for young people who become pregnant.

5.13 Health practitioners are familiar with the CAF, trained and aware of its use and whilst the process is respected they are generally reluctant to complete it due to perceived burden of becoming the lead professional.

5.14 There is good cross- agency working around domestic abuse, with representation on the MARAC by a safeguarding named nurse for community provider. Training and awareness across partners is good and A&E departments work closely with Worth (contracted provider) to identify women who are victims and refer the appropriately with most referrals coming through this route. The 4 MARACs in county each meet monthly and deal with 1600 cases annually, although there is good awareness of need and an estimated 3500 women are likely to need support. Around 75% of attendees have children (almost three quarters of these with very young children) but there is insufficient direct support for children who are victims of domestic violence, with most work being with adults or parent-child. However, adult mental health services have not engaged effectively with the MARAC. Referrals to MARAC from education, social care and health services are low, the reasons for which have yet to be fully investigated.

6 Outcome 7 Safeguarding

6.1 Sussex Community NHS Trust has 3 safeguarding named doctors in post but these duties are not in their job descriptions and there is no contracted protected time or formal management oversight through job plans. A recent review of safeguarding staff across the community provider has proposed named nurse numbers are reduced from 6 to 3 but the roles will be strengthened with clear job descriptions and protected time.

6.2 St Richards Hospital (RYR16) has effective provision for safeguarding, with a dedicated children's accident and emergency service open until 10pm every day and CYP still have access to the unit after that time when necessary. There is always RSCN on duty, all clinical staff have undertaken safeguarding training at level 3, and receptionists have undertaken level 2 training. The accident and emergency department has an effective system in place to alert staff to safeguarding issues in relation to children who attend and are also able to implement alerts to raise awareness for staff. The system is available as a cause for concern alert in the urgent treatment centre at Crawley. A liaison health visitor ensures that all young people attending accident and emergency and within the urgent treatment centre are reviewed and other agencies alerted. The Worthing site was not visited as part of this inspection; it is in the process of improving its service provision in line with St Richard's A&E

6.3 Safeguarding engagement and systems within the maternity services are effective. A monthly concerns meeting includes representation from midwifery staff from the ward and community, health visiting and children's social care services. Shared information is held in a social concerns file on the labour ward so that when a young mother arrives on the unit, staff are immediately alerted to any concerns and are able to implement appropriate care or inform other agencies at an early stage.

6.4 There are good relationships between partners in the forensic/sexual abuse allegation service – although reliant on a single paediatrician to perform examinations the service is responsive and there is support from the police and social workers, with findings being taken seriously. The service is commissioned as part of a rota with Brighton, Mid Sussex and (weekends) East Sussex. It is anticipated that an improved service with dedicated facilities will be in place during 2011.

6.5 The role and function of the designated doctor for safeguarding is currently under review in the light of the changing provider arrangements. The PCT is working closely with dentists to improve knowledge and understanding of safeguarding issues. Children with special requirements are flagged on care records and an assurance system is being developed.

6.6 There are a number of jointly funded Approved Mental Health Practitioner posts within Sussex Partnership NHS FT (RX2) and the LA. These are senior practitioners who lead on practice development and training for staff. There is a willingness to co-operate by the adult mental health team which works pan-Sussex, but there is poor involvement in MARACs and no substantive named nurse in post for children.

6.7 There is a Named GP who undertakes two funded sessions, (one day per week), plus an extra session available on a “bank” basis which provide protected time for safeguarding across county. Four workshops on safeguarding and child protection have been held in the last year for GPs with attendance of 200, and it is evident that this has raised awareness of child protection and safeguarding practice amongst GP’s. Child protection and safeguarding training has been has been well attended and well evaluated. The training also included Practice Managers, who then were able to cascade training to reception and other administrative staff. This training is planned to be on going and updated as required.

6.8 An audit of GP practices in Dec 09 had 91 out of 93 responding and many requests for training etc, The PCT’s “What to Do...” referral flow charts were universally welcomed by practices, as was the provision of a trained GP Advisor to be contactable when CP advice is needed. There were clear findings and recommendations from the audit which are being taken forward. Only 5% of practices have a named social worker.

6.9 There is an innovative Children’s Liaison and Integrated Care group (CLIC) set up in one GP practice in Worthing that brings together multi agency staff which includes representation from all GP’s in the practice, Health Visitors, Social Workers (to date a Service Manager has attended), CAMHS, School Nurses and the LAC Nurse. Midwives are also invited be to date have not yet attended.

6.10 The group meets once a month and allows “real time discussion” of a number of pre planned cases via electronic presentation and always ends in agreed actions by the various agencies and has seen outcomes for CYP improve due to the earlier interventions and joint working. There are effective training and development strategies across the PCT, Acute and Mental Health Trusts. This has seen a continued increase in the total numbers of staff attending training in child protection and safeguarding.

6.11 Services for disabled children are provided from four child development centres and benefit from collocation and good interagency communication within health despite variations in host trust for clinical staff. However engagement with the social service disability team is poor, with referrals being rejected and a sense amongst staff that their concerns around neglect and early child in need support are ignored until a child protection incident occurs. Senior managers are beginning to address this issue working across teams to improve the quality of referrals and agree thresholds.

6.12 There is good learning from serious case reviews (SCRs) across health partners, with quarterly reporting through the Quality management group; the PCT is developing a wider strategic view of risk and uses SCRs from other areas to consider applicable lessons for West Sussex.

6.13 The Child Death Overview Panel meets regularly, is chaired by a Police representative and has good attendance but with around 60 deaths a year, 50 of which are perinatal and no neonatal unit, drawing conclusions and recommendations from trends can be a challenge. Returns of data forms from outside the area have improved since the appointment of an administrator to the panel and the performance of the rapid response arrangements have improved significantly since the appointment of a rapid response nurse. Outputs included a review of provision of bereavement support for families and identified a gap in the service which the partnership are working with voluntary sector providers and the north and south teams to provide improved cover.

7 Outcome 11 Safety, availability and suitability of equipment

7.1 It is reported that there are no issues with procurement of equipment across children's services

7.2 Clinical care for children is delivered in appropriate child friendly environments across acute services. Within acute sites, visited at Western Sussex Hospitals NHS Trust (RYR), St Richards Hospital (RYR16) and Queen Victoria Hospital NHS FT (RPC), children's wards and out patient settings have secure entry and some areas have CCTV in place.

8 Outcome 13 Staffing numbers

8.1 Concerns have been raised over health visiting capacity and caseloads in two areas of the county which have been raised as risks by the team and are being addressed by the provider trust management together with the PCT commissioner. Caseloads range between 280 and 460 children, Staff turnover is above the national average but is starting to decrease and vacancies are reducing . Sussex Community NHS Trust has been focusing on developing skill mix in health visiting teams and undertaking Return to Practice programmes which we are looking to develop and support as part of the Sussex Workforce Hub model. Sickness is high at over 5% which needs to be monitored and will be addressed with the Trust at the next contract quality review meeting

8.2 School nurse caseloads are high, with reports of up to 40 LAC within one school – a team of 4 has up to 150 Looked after children, but there is good backup and support from the LAC nurse team.

. 9 Outcome 14 Staffing support

9.1 There are effective training and development strategies across the Primary Care Trust, Acute and Mental Health Trusts with appropriate evaluation and monitoring of the training delivered for child protection and safeguarding. Within the Acute Trusts, all staff have received training at level one, and staff working with children have received either level two or three, as appropriate to their role and contact with children and young people. At Queen Victoria NHS FT, 76% or eligible staff are trained at level 1

9.2 The designated nurse is a safer recruitment trainer and has delivered training to health partners or they have received it through LSCB.

9.3 There has been specific, tailored training for GP practices led by the named GP, which has been well attended and well evaluated; 220 out of 543 staff eligible have attended (40.5%) . The training also included Practice Managers, who then were able to cascade training to reception and other administrative staff. This training is planned to continue and be updated as required, and links with a toolkit for practice managers. 220 out of 543 in West Sussex - 40.5% of GPs attended CP training

9.4 Supervision of staff involved in safeguarding is strong and included clearly in policies. An audit was undertaken in 2009 and another by South Coast Audit in May 2010. All healthcare groups have regular access to various levels of supervision, either by line managers, peer and group or from external sources. It was reported as a result of continued supervision and support received, staff feel confident in implementing referrals and escalating concerns but there are concerns that changes to the named nurse arrangements in the community service will reduce the quality and effectiveness of supervision.

9.5 There is appropriate evaluation and monitoring of the training delivered for child protection and safeguarding. Within Western Sussex Hospitals NHS Trust 100% of staff have received training at level one; staff working with children have received either level 2 or 3 as appropriate to their service provision and contact with CYP. There is good monitoring by the training and development department. Safeguarding is a mandatory objective within the appraisal and performance reviews for staff and this is also linked to the key competency framework for nurses and therefore links with career and pay progression.

9.6 Within Sussex Community NHS Trust,80% of staff are trained at level 1 but only 23% (109) of 494 staff have currently accessed training at level 3 – with 385 requiring training before 31 March 2011. There are nine specialist child protection roles within the trust. Seven of these staff have attended specialist updates in 2010.
All CAMHs staff reported training to level 3

10 Outcome 16 Audit and monitoring

10.1 Oversight of safeguarding within the Primary Care Trust is better with clearer performance monitoring and reporting arrangements. A number of internal and

external audits of safeguarding practices have been undertaken within the last year across health services which provide greater assurance of the robustness of safeguarding systems. Where recommendations have been made, these have been appropriately followed through.

10.2 The independently commissioned south east audit reviewed safeguarding arrangements and rated the PCT as ”significant assurance”, with actions around provision of child friendly environments and some concerns around GPs feeling somewhat isolated from the safeguarding system due to recent changes. The introduction of GP training across the county aims to address this

10.3 The PCT conducts an annual audit of record keeping (Oct 2010) which is monitored by the LSCB. The PCT safeguarding policy has clear standards for providers and independent contractors.

10.4 An audit of safeguarding arrangements within GP practices generated a response from 91 out of the 94 practices across the county and work is on going to share and improve safeguarding practices.

10.5 An audit of named nurse activity was conducted for 2008-9 which has informed the redesign of services, and a restructuring of the community nurse arrangements has taken place for Sussex Community NHS Trust.

10.6 There are satisfactory monitoring arrangements of safeguarding across acute healthcare groups. There are a range of quality and effectiveness steering groups that ensure that clinical practice within safeguarding is appropriately monitored, reported and shared with key partners. These include weekly safeguarding review meetings which are multidisciplinary held in A&E department, children’s services and maternity.

10.7 The LAC team have developed the PIMs information management service which facilitates good data collection and generates a database of A&E attendance, health assessments, to improving monitoring and effectiveness. Communication across the service and with social care partners is good and (through the PIMS community health information management system) all LAC in the area are accounted for and their location and healthcare status is known by all relevant healthcare professionals. This enables follow up where YP fail to engage with substance misuse services, for example.

11 Outcome 21 Records

11.1 The quality of LAC health records is variable.

11.2 From 10 files examined, only one file demonstrated that the initial health assessment was undertaken within the statutory time scale of 28 days, with one assessment undertaken almost a year after referral. Health records demonstrated the placement type, ethic origin and CYP location, with change sheets completed in the event of any change of location.

11.3 There is a general lack of information, with chronology sheets for significant events blank in all cases. This was despite one young person having significant mental health issues and inpatient episodes of care at tier 4 under care of Sussex

Partnership NHS Trust (RX2). There was no record of the reported continued significant CAMHS interventions.

11.4 It was also reported that the LAC Health team was only alerted to the needs of one YP with acquired brain injury when the allocated social worker had contacted the team to organise resuscitation training for the birth mother in case of any acute emergency when the young person was on weekend visits. Appropriate assessments were then undertaken, which ensured that immediate health needs were met.

11.5 Immunisations were up to date in all cases examined. There had been a delay in one case but this was due to the child having had chicken pox. The follow up to ensure the immunisations were completed was undertaken and recorded within an appropriate timescale. All CYP are registered with GP and, with the exception of one YP, had been referred to a dentist. Two of the YP are not well engaged with health and have refused continued health interventions from the LAC health team.

11.6 Although social workers reported good communication links with health staff, there was only one file that contained evidence of the LAC review and documented shared information.

11.7 One child was an unaccompanied asylum seeker (UASC). The initial assessment was comprehensive and was undertaken with the assistance of an interpreter, by a GP with special interest in UASC. This was undertaken within 10 days of arrival into the country. Immunisations were completed as per the agreed algorithm, and the health care plan had identified the need for a chest x ray and blood tests due to a possible heart/lung problem and these had been undertaken within an appropriate timescale, with no continued health needs identified.

12 Recommendations

Immediately

Joint - Ensure that thresholds for and purpose of the common assessment framework are clearly understood and applied across the partnership

Within 3 months (including those directly relevant from the joint report)

Partners to develop a sexual health/teenage pregnancy strategy and plan including LAC

The LSCB should ensure regular attendance by key partners at the multi-agency public protection meetings and the multi-agency risk assessment conferences.

The LSCB should review the purpose and function of multi-agency core groups to ensure that they are regularly held, have appropriate agency representation, and systematically implement, review and develop the plans of protection made at child protection conferences.

The LSCB should review attendance and engagement by partner agencies at case conferences and strategy meetings to ensure that appropriate input is provided to improve outcomes for children and young people.

Review user involvement arrangements across health partners, for example the "You're Welcome" criteria

Within 6 months

Formalise arrangements for the designated LAC doctor to improve consistency and quality of initial health assessments for LAC.

Strengthen the management of community health teams to clarify their responsibilities, risk assessment and working arrangements, including safeguarding support functions.

Ensure that the designated and named doctor roles across the Primary Care Trust and community providers are appropriately defined, resourced, contracted and performance managed.

Appoint a designated doctor for looked after children

13 Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of the final version of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.