Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children’s Services in Nottingham City

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<th>Date of Inspection</th>
<th>29 November - 10 December 2010</th>
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<td>Date of final report</td>
<td>24 January 2011</td>
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<td>Commissioning PCT</td>
<td>NHS Nottingham City</td>
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<td>CQC Inspector</td>
<td>Tina Welford</td>
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<td>CQC Regional Director</td>
<td>Dr Andrea Gordon</td>
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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.
Safeguarding Inspection Outcome

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<td>Overall effectiveness of the safeguarding services</td>
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Looked After children Inspection Outcome

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<td>Overall effectiveness of services for looked after children and young people</td>
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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.

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:**

Planning and commissioning of universal and specialist child health services and primary care is undertaken by NHS Nottingham City. Universal services including health visiting, school nursing, community midwifery and the specialist safeguarding team are provided by CitiHealth Nottingham. Paediatric therapy services, special school nursing and the children in care nurse led service are provided by Nottinghamshire Community Health. Hospital services including accident and emergency services for children and acute maternity services are provided by Nottingham University Hospitals NHS Trust (NUH). Children and families access primary care through one of 62 GP Practices, the Nottingham Walk in Centre and Nottingham Emergency Medical Services (NEMs).

A number of organisations work in partnership to provide child and adolescent mental health services (CAMHS).

- Tier 2 targeted community CAMHS services are provided by Multi-Agency Liaison Teams (MALTs) based at Nottingham City Council.
- Tier 3 specialist and tier 4 highly specialist services are provided by Nottinghamshire Healthcare NHS Trust.
- Specialist Tier 3 CAMHS learning disability services are provided by Nottinghamshire Community Health.
- Specialist counselling services for children who have been sexually abused are provided by Action for Children and the Sexual Assault Referral Centre (SARC - aged 13 plus).

Joint commissioned services with the local authority include: individual packages for looked after children and children with complex health needs (under a section 75 arrangement); services for disabled children including health support for short breaks and in schools; services to support reduction in teenage pregnancy, support in children centres including Healthy Childrens Centre standards.

The Nottingham City Children’s Trust arrangements are delivered through a Children’s Partnership Board and an Executive Group known as the Senior Officers Group. A wide range of agencies are involved including Nottingham City children and families service, the Primary Care Trust, Strategic Health Authority, Nottingham City Safeguarding Children Board (NCSCB) Chair, Police, five schools representatives, Nottingham Governors Association, Learning and Skills Council, Probation, job centre plus and representatives from the voluntary sector. The Nottingham City Youth Council also has three representatives who attend the Board. NCSCB is chaired by an independent chair and brings together the main organisations working with children, young people and families to deliver safeguarding functions.

1 General – leadership and management

1.1 There is strong and visible strategic health leadership and management, and strong partnership working with the council and other partners. There is a clear
strategic direction within the children and young peoples plan (with health being one of the priority areas) underpinned by an effective joint strategic needs assessment. Strategic plans are in place, which explicitly highlight safeguarding as a top priority, suitably underpinned by joint resources. There is a long tradition of effective joint working, including joint commissioning, which is visible at all levels within health governance structures and through arrangements with partner agencies. Co-location of community services within children centres and social care has commenced and is already showing improved communication with social care, especially relating to safeguarding issues and concerns. Partnership working with both social care and the voluntary sector is good, demonstrating good levels of impact, within the current climate and local economy.

1.2 Policies and procedures relating to safeguarding children and young people and looked after children are well embedded. All staff interviewed were aware of, and able to use, the electronic links to find the most up to date versions of the relevant documents. Implementation is effectively monitored through the individual organisations’ risk and governance structures.

1.3 The designated health professionals are members of the Local Safeguarding Childrens Board (LSCB) acting as advisors to the board. These staff are fully involved in developing and providing multi agency training, which is assisting with the effective dissemination of the outcomes of audits and serious case reviews. There are differing views, however, as to how effective communication has been on general issues from the LSCB, although staff report that when there is a specific communication plan, such as those relating to an action plan implementation following reviews, communication is more effective. All health staff who attend the LSCB sub groups report that there is a good level of challenge and members are held to account on behalf of their organisations. The health annual safeguarding report is submitted to the LSCB for information, prior to public publication and is effectively scrutinised.

1.4 Primary care practitioners whose roles require them to attend both the Nottingham City and Nottinghamshire County LSCB reported that there is no or very limited sharing of learning from serious case reviews within the respective geographical area, which is a missed opportunity to enhance practice.

2 Outcome 1 Involving Users

2.1 There is good involvement of service users (including looked after children) in service evaluation; however there is no systematically feed back to the users on how their views are being used. The Child and Adolescence Mental Health services (CAMHS) have involved both parents and young people in information leaflet designs, which have resulted in the promotion of the services available to young people in a non-stigmatised manner. ‘You’re Welcome’ accreditation is being implemented across all health providers. Base 51, (a voluntary sector provider, offering holistic physical and emotional support for young people 13-25 years of age) was the first service to gain accreditation and as a result service users have supported and trained other young people to become inspectors as part of the LSCB staff training programme. There are a number of other providers who are awaiting
regional sign-off or are in the process of becoming accredited at the time of the inspection.

2.2 There is good user participation within all sexual health services, all of which are currently at various stages of the process, to achieve the ‘You’re Welcome’ standards. Young fathers have been consulted as to their preferred involvement, and through Children Centres, a number of dedicated well attended sessions have been held for fathers, including four dedicated city wide events across the year. As a result a number of young fathers are now frequently attending sessions with their child (children) at the Children Centres, which is ensuring that emotional support mechanisms are effective for the whole family. There has been a recent initiative within health visiting and maternity services to identify invisible fathers and to engage fathers, wherever the mother agrees, in the child’s care. However due to the early stage of development, the overall impact is yet to be realised.

2.3 The short break provision has been reviewed by the local Parents Partnership, which has resulted in a review of the service. The outcome has been an increasing range of flexible short break provision for both disabled children and those with life limiting and complex needs.

2.4 All parents seen during the inspection reported that, even though they had health reports on their child’s level of disability, and in some cases, were receiving higher level of carer payments due to the severity of the condition, or their child’s condition was worse than that of a sibling who was already accepted by the team, their child still had to be referred twice to the children with disabilities social care team before acceptance. Parents were unclear as to the rationale for differing thresholds; some parents had been given conflicting information from family support workers, social workers, and on occasions, from health services, leaving them feeling frustrated and their child experiencing a delay in getting the services that they required. Parents stated that they had raised these concerns through their voluntary sector support groups; however they felt this issues had not been effectively addressed, or they were not given feedback on actions being taken to address their issues.

2.5 Awareness and addressing of equality and diversity is good, with dedicated health roles having been established. There is a good dedicated unaccompanied asylum seeker clinic, with good access to interpreting and translation services with specific interpreters trained for sexual health services. Further there is good use of interpretation services within the dedicated Asian speech and language therapy treatment sessions. Interpreters have been trained in the skills required for assessment, as well as interpretation. This has enhanced the quality of services provided to these children and their families.

2.6 The dedicated midwife for female genital mutilation (FGM) along with the dedicated care pathway are working well, with good identification and support for young women, who may have been subject to mutilation.

2.7 Those staff working through the Children Centres provision have a good access to families and the local community leaders, resulting in a fall in the ‘do not attend’ rates. This has been helped by the good access to interpretation services at the clinics held in the Children Centres. Dedicated clinics are held, for example, for
Polish mums and another for Kurdish mums, which has improved the engagement of these mothers with statutory services and reduced social isolation. A more recent development has been with fathers, who are now attending these groups, as they have seen the benefits for their wives.

2.8 There is a good range of information for parents of children with disabilities; however the use of this has not been evaluated especially in accessibility for parents and new parents moving into the area.

3 Outcome 4 Care and welfare of people who use services

3.1 There is good awareness of social care referral thresholds, however there were a number of incidents reported when staff had to make the same referral twice before it was accepted. Senior medical staff report that they have only recently been informed that the referrals are screened by unqualified social work staff, who on a number of occasions had questioned their medical knowledge and clinical judgement. These concerns were also echoed by general practitioners who reported that, in their view, the child must be at an immediate risk for action to take place, and that a ‘child in need’ would not always reach the thresholds for further intervention. The unqualified social care staff are experienced staff and work under the direction of a qualified social worker. Examples were given of how the escalation procedure had been successfully implemented to resolve concerns when there were differences of interpretation of ‘thresholds’ between health and social care staff. However, staff remain concerned that the use of escalation brings further delays in ensuring the safety of the children concerned. Health staff reported that they frequently do not receive feedback on referrals from social care. Feedback, if any, is received via the named nurses or the highly valued health visitor liaison post for emergency department staff.

3.2 The health of looked after children is good. There is a highly valued dedicated health looked after children and adoptive team, with effective partnership working and information sharing supporting the comprehensive health needs which are sensitive to the individual cultural needs. The team undertake monthly benchmarking audits of practice and cases, mapped against current national statutory guidance. Six monthly quality audits of case notes are undertaken mapped to the Statutory Guidance on promoting the Health and Well-being of Looked After Children (including national indicators and other locally identified indicators related to physical and emotional health to support improvements in practice). Outcomes show improving and sustained results.

3.3 The standard of the health assessments seen were of a good quality. However, the health action plans timeframes are not always written with measurable dates. One record reviewed showed that the annual assessment was due December 2009, there was no evidence to show that this took place or reasons why this had not taken place, the records show that a health assessment actually took place in May 2010. Strength and Difficulties Questionnaires (SDQs) are not used as part of the health assessment, however, there is some evidence on the files seen that emotional well-being is reviewed. Overall, the use of SDQs is yet to be embedded fully in emotional well being and annual health assessments. Health staff report that the foster carers report gives more detail and is more beneficial in identifying
issues for discussion at health review meetings. Case based discussion are held on a one to one and group basis, which provides support to staff, reviews interventions and, agrees further assessments, reviews and treatments. This process ensures timely and appropriate interventions for young people whilst supporting their carers.

3.4 The dedicated Looked after Children (LAC) Child and Mental Health services (CAMHS) including the dedicated learning difficulties and disabilities service, (the latter of which works well as part of the multi agency locality teams (MALT) service), provide effective consultation to professionals and supports delivery of tier 1 work. The CAMHS LAC team eligibility criteria is for young people under the age of 18 years and is for Nottingham City looked after children only, there is a dedicated care leaver service which addresses needs more appropriately. The dedicated CAMHS care leaver worker provides a good level of support for care leavers and supports their transition to adult services, if required. CAMHS provide services within all the four tiers, through locality working and specialist teams, delivering a comprehensive approach, which meets the current identified needs of the local population. There is generally good and timely access to twelve tier 4 beds ensuring that there are minimal delays and treatment regimes continue. The beds are shared with the neighbouring county which at times may affect capacity.

3.5 Annual health assessment processes are well established, including the gaining of consent which is suitably embedded, (including the requests for out of area placed children and young people). The current full year data (March 2010), shows health assessments at 83.9%, immunisation rates at 87.9% and dental assessments 83.6%, all above England averages. Good tracking and monitoring systems are in place ensuring that health assessments are completed on time for all looked after children irrespective of where they are placed, with successful follow up of children and young people who did not attend appointments. A flexible approach is taken when selecting venues for health assessments, including the use of joint appointments for assessments (for example, with CAMHS) which is improving attendance.

3.6 Health action plan monitoring is undertaken by social care staff for all looked after children; however the dedicated LAC health staff monitor compliance at the review meetings. LAC specialist nurses are now attending LAC review meetings with social care colleagues, which is helping to ensure that health action plans are discussed and actions completed, even if the young person is placed out of Nottingham City. Carers (foster and residential care home staff) currently do not routinely receive copies of the health action plan, however more recently this practice has changed. There is no evidence in the health files reviewed to show that staff are receiving supervision and the effect this is having on practice.

3.7 There is inconsistency in the comprehensiveness of health service provision for care leavers, (this has already been recognised as a gap in provision), and a business case has recently been submitted for dedicated staff. Social care staff acknowledge that the pathway plan ensures that the individuals’ health data is included in the leaving care information; however there remains an inconsistent approach with some care leavers not receiving comprehensive information. New adoptive parents will receive copies of immunisation and vaccine data and in some cases health staff duplicate the ‘red’ child health record book, as the birth parents
often retain the original copy, to ensure that their birth and health history up to the adoptive time is as complete as possible.

3.8 All health staff involved in working with looked after children are ‘C-card’ scheme trained, so are able to provide contraceptive support through this and the ‘clinic in the box’ approach. As a result, staff report, this has helped reduce the number of conceptions, which can be seen in the overall reduction in the number of teenage conceptions within the city, currently the lowest since the 1998 baseline, as well as delaying second conceptions.

3.9 There is good engagement and support for the Teenage Pregnancy Partnership Strategy, which has refocused activity to continue the reduction in the rate of teenage conceptions. Work streams are now focussing on young men and young Dads; as a result there has been an increase in the number of young men joining the c-card scheme. A sexual health outreach worker has been employed for the Asian community; the role is promoting a culturally sensitive service with good access to both contraceptive and sexual health services.

3.10 The family nurse partnership is providing effective intensive support for young women from the point of conception until their child is two years old. This support has resulted in the reduced isolation and reduced number of second conceptions within teenagers by improving self esteem. Closer partnership working with social care and other agencies, such as housing, has reduced the vulnerabilities of both the young woman and their child.

3.11 Community staff effectively work alongside the Healthy Schools programme teams, using outcomes of surveys to identify risk groups within individual schools, such as substance misusers, and providing effective interventions and support to teachers in address issues. There is good engagement of schools with the healthy schools programme. All schools have now engaged with the universal provision for drug, alcohol and substance misuse services; this includes good involvement with other agencies such as the police and youth offending teams. School nurses are commissioned to provide only targeted sexual health and relationship work within schools, which although seen by school staff as limited provision, is meeting the current needs.

3.12 School nurses have good links with the nominated teacher for safeguarding and the special needs teachers, attending statement and educational review meetings, and transitions meetings, thus ensuring that health information is shared effectively. As a result of these meetings and the use of the common assessment framework (CAFs), especially with those children with disabilities, smoother transitions to other schools and services has been identified. Early intervention and support initiatives are currently being embedded into practice for children and young people with disabilities and the ‘team around the child’ concept is starting to work more effectively.

3.13 The good integrated approach used by the co-located teams involved in transitions (including those leaving school to further education) through the single access process, has started to ensure that there is early planning and sharing of
health information as well as opportunities for further education and training tailored to the young person’s needs.

3.14 There are good joint assessments and on going health reviews undertaken with both consultant paediatricians and adult health consultants from year 9 (within school), which has improved transitions, reducing the 'do not attend' rates and ensuring that health action plans are effectively developed, agreed and shared between all professionals.

3.15 Multi-agency staff (education, health, connexions, social care) from the sexual health services have all received dedicated themed safeguarding training up to level 3 supported by the LSCB. This training has enabled to staff to recognise early signs of vulnerability and following reflection on training a revised risk based comprehensive sexual health safeguarding pathway is being developed. Further this pathway builds on the current pathway, but contains refined risk tools which enhance the safeguarding risk assessments for all young women accessing sexual health services.

3.16 Parents of children with disabilities interviewed during the inspection, raised concern over the lack of social care occupational therapy and speech and language therapy in secondary schools, which they feel is inhibiting their child’s development. Therapy staff report that, in most cases, the need for speech and language support is not required in such an intensive way within secondary schools compared with early year provision. However the expectation of parents is not well managed. Parents value the consistent and approachable paediatric medical teams, with the same doctor seeing the child until they are eighteen years old, thereby providing continuity of care.

3.17 There is good integrated working with the children with disability staff from all agencies and providers, with commissioners being responsive to identified needs, with creative solutions, enhancing the lives of the young people and their families. Children with disabilities are a priority area within the children and young peoples plan and through the joint strategic needs assessment, there has been good mapping of local needs with national trends. This mapping has been effectively used in planning and commissioning services. Through good communication health, children centre and social care staff have reviewed the use of the assessment process and with the use of the CAF, have enabled smarter and joint assessments reducing the burden on the young person and their families.

3.18 The community paediatricians and other health staff are now working together to ensure early identification and diagnosis of disabilities and life limiting conditions. This is ensuring that timely and appropriate interventions, treatments and support with onward referral at appropriate times and to appropriate agencies is taking place.

3.19 Nottingham University Hospitals NHS Trust is a regional centre for clef lip and palate surgery, as well as being a national centre of Tourettes and therefore staff are often supporting families that are not from the local area, ensuring that appropriate referrals are made to the local services where the family reside. As a regional centre staff have been able to enhance their knowledge and skills of these conditions, which has a positive benefit for Nottingham City families.
3.20 Children centres are working effectively with Portage services and health visitors in supporting families with young children. Following staff training in health and safety, prevention of accidents and safeguarding staff are now able, on an individual basis, to assess and support families with disabled children up to two years of age and provide equipment to safeguard the child within the home setting.

3.21 Base 51, has provided very successful support for young people with up to 50 daily contacts. These are often the traditionally ‘hard to reach’ individuals for statutory services, often using drugs, substances and alcohol. The service supports young people, for example, to find suitable accommodation to remain safe and minimise or reduce the risks of being exploited, as well as running sessions such as anger management workshops.

3.22 There is effective and close working between CAMHS, Base 51 and the community paediatric teams for those individuals diagnosed with a learning or physical disability especially with the increasing number of referrals for those with autistic spectrum conditions. This is ensuring that treatment regimes are complementary and goals are shared. Attention Deficit Hyperactive Disorder (ADHD) was identified as a gap in service provision and following intervention and support from the National Institute for Health and Clinical Excellence (NICE), a joint adult and CAMHS service was developed, which is nearly at the end of its first year. The impact of this service has been to meet the gap in provision and ensure smooth transition between services, as well as supporting adult clinicians to develop their competence in prescribing medications for this client group.

4 Outcome 6 Co-operating with others

4.1 All referrals to CAMH services are through the social care teams, however health staff can refer directly for consultation without going through the social care referral process. LAC health staff report that feedback from referral requests and information for monitoring of the health action plans is inconsistent. The need for clearer feedback mechanisms has been identified, although no action has been taken to date to address this. Unscheduled care settings are unable to refer young people who have self harmed directly to CAMH services; the young person has to be admitted and the consultant paediatrician (who may also be the same doctor on rotation and covering ED) has to make the referral from the ward. Staff reported that if the young person is medically fit for discharge, but the referral has not been made by midday, that the young person must remain, often unnecessarily, in hospital for another day until CAMHS staff have assessed them. In some cases consultant paediatricians, based on risk assessments and telephone consultations with CAMHS consultants, will discharge the young person and a follow up out patient appointment for CAMHS is given. This process is felt to increase the rate of engagement with services.

4.2 There is good engagement of health providers, including general practitioners, with report production for case conference and serious case reviews and, as appropriate, attendance at meetings. There is effective dissemination of the outcomes following serious case reviews, individual management reviews and child
death reviews within the acute and community sectors especially, however this is not replicated throughout all primary care settings. There is currently less effective dissemination of the outcomes of serious incidents; however the processes have been aligned to improve communication. The designated and named health professionals as well as the health visitor liaison staff, provide highly valued feedback of all referrals and incidents. Staff reported receiving regular e-newsletters relating to safeguarding.

4.3 The highly valued domestic violence specialist nurse is co-located with the police domestic violence team. This has improved joint working arrangements and sharing of intelligence. There are now two dedicated midwifery posts that are developing and enhancing maternity care for women subject to domestic violence. The police fax information to the safeguarding team about any incidents of domestic violence where there were children within the home. This information is then disseminated to community staff who will follow up high risk cases, to ensure the child is safe and assess whether a safeguarding referral is required. If needed, a common assessment framework is commenced, with good engagement of all professionals including the police. These processes are ensuring that the victims of domestic violence and the unborn baby are protected in line with the victim’s wishes.

4.4 There is good partnership working between all frontline health, social care and police staff, including the voluntary sector all of which are ensuring that there are swift responses to addressing the needs of children and young people. Where required there is good joint working with the youth offending teams. Further examples include the well embedded referral pathways for staff in the youth offending teams for young people experiencing mental health as well as substance misuse concerns. There is effective use of the common assessment framework (CAF) and pre-CAF, which is used successfully to instigate the team around the child approach. This approach is being successfully used with children who have either learning and/or physical disabilities, using the team around the child approach to effectively identify and reduce their vulnerabilities.

4.5 Staff from children centres and health visitors are working well together by undertaking joint visits and linking with the YMCA young parents and young mums groups. This is ensuring that these parents are able to access services and do not feel inhibited. Early results are showing that this is working well, with better engagement within the younger parent group for those aged fourteen to seventeen years, with the users reporting feeling less stigmatised.

4.6 Community based staff that are now co-located with other agencies and those based and working out of Children Centres have noticed improved communication and enhanced working with other agencies which they reported, in the past would not have occurred. As a result of this, staff report improved identification and communication relating to vulnerable families with enhanced sharing of information resulting in an increase in safeguarding referrals being made.

4.7 There are good links with the family nurse partnership, providing support to those looked after young people whose babies are in care, ensuring that they are able to remain in contact with and see their child. Due to the involvement of the family nurse partnership there has been an increased take up in contraceptives,
which staff believe is reducing second pregnancies. Looked after young people have good access to mainstream contraceptive services, whilst in the clinics young people may also have their annual health assessments at the same time, thereby ensuring that information is fully integrated, preventing duplication and further appointments which within this group are often not kept.

4.8 The looked after children health staff provide a good range of well accessed training for other professionals, foster carers and new adoptive parents. Looked after children health staff are members of the fostering parent approval panels and contribute to the three day pre-selection training and evaluation of foster carers, which is ensuring that the carers are fully aware of health issues and any long term health issues that the looked after children will face. Training is also provided on a one to one basis, examples included sexuality, living with same sex parents, substance misuse and foetal alcohol distress syndrome. These approaches are helping to ensure and maintain long term placement stability.

4.9 Following the introduction of the ‘Drug Aware Project’, staff have received training and the Ngage assessment toolkit (which has good links to the CAF) is now in use. This has resulted in a significant increase in the number of referrals to the substance misuse team. The Compass Young People’s Substance Service are now seeing more young people with dedicated substance misuse workers appointed to manage the increase in referrals. There are good links with the maternity services and adult services to reduce the vulnerabilities of unborn babies, children and young people, where adults are substance mis-users. The dedicated WAM (What about me) service, for young people between the ages of 5-19 years, is providing highly valued support. A pilot project with Relate, offering relationship and family counselling to families, has commenced and is yet to be evaluated.

5  Outcome 7 Safeguarding

5.1 The contribution of health agencies to keeping children and young people safe is good. There is an effective twenty four hour, seven day a week on call safeguarding service, provided by the designated and named health professionals, which is highly valued by all health staff. This service ensures that health staff are able to speak to a health professional for advice and support or if they need to escalate a safeguarding referral with social care staff. Staff contact the highly effective domestic violence specialist nurse, who visits Nottingham University Hospitals NHS Trust children emergency department, when on duty to support staff, however there is only one practitioner and capacity therefore is limited at times.

5.2 The designated nurse is a ‘safer recruitment ‘trainer and has delivered training to health partners through the LSCB programme, ensuring that compliance with statutory requirements is met.

5.3 Parents and carers of looked after children seen during the inspection, all spoke highly of the support and continuity that they receive from the dedicated looked after children health staff. This continuity however, is not matched with social care services, which leaves the parents/carers feeling frustrated and isolated at times.
5.4 The Child Death Overview Panel (CDOP) meetings are well attended. Currently there is no lay representation but there are a number of regular observers to the panel. The CDOP chair, who is the designated doctor for safeguarding and sits on the SCR panel, ensures that the functions of both groups are complimentary and lessons learnt are effectively shared. CDOP members hold regular training events, but there has not been a recent training event for general practitioners; plans are in place for several events to take place in the New Year. Policies and processes for both expected and unexpected child deaths are well embedded, and subject to regular review.

5.5 The quarterly and annual CDOP reports are effectively scrutinised by the provider and commissioner health trust boards, LSCB and the Children Partnership Board. Through the action log database, action plan monitoring and any slippages are accounted for, which is ensuring that the named responsible individuals for each action are able to provide robust evidence of implementation.

5.6 There is an effective child death rapid response team covering seven days a week 7am to 7pm with an on-call service out of hours. Good police liaison is in place when there has been a sudden infant death, with community paediatricians and the police attending the home together and taking joint statements, which is assisting with the provision of support for both families and staff. The dedicated rapid response team is able to ensure that strategy meetings are held within 24 hours of a death being reported, thereby implementing all the correct procedures promptly. This well embedded rapid response team, through good liaison with health visitors and the child bereavement nurse, provide families with prompt and effective support at the time of a child’s death. Very positive feedback from parents who have been supported through the bereavement has been received. NHS Nottingham City medical director receives regular updates and annual reports which clearly identify lessons and the implementation of these lessons within practice. However those GPs interviewed reported that they do not receive information resulting from a child death unless they have been involved in the actual death, therefore restricting the opportunity to enhance practice.

5.7 A number of information leaflets have been produced following child death reviews with support of parent bereavement groups and local bereavement support organisations, some of which have been jointly produced with Nottinghamshire County LSCB, to enable learning across both councils. However the CDOP members recognise that more information and publicity of their role is required within the general public and GP forums; events are planned for the coming year. There has been, since the publication of the co-sleeping information leaflet for parents, a reduction in the number of child deaths attributed to co-sleeping. There is good use of both local and national networks to share learning and develop practice which includes good links with the coroners’ office.

5.8 Nottingham University Hospitals NHS Trust children emergency department (ED) staff do not have access to the up to date child protection register held by social care and therefore have to contact the duty teams for information relating to any child, including those looked after, to obtain information and establish, where relevant, who has consenting authority. Out of hours, this can take over an hour to receive a response as there is only an ansaphone service. This slow response time
was reported by general practitioners in working hours as well which was of greater concern as they find it difficult to keep the family in the practice whilst awaiting a response. The standard set is that social care staff return calls within 30 minutes; this delay often results in a clinical decision being taken to admit the child to hospital, to ensure that the child remains safe. These concern have been raised with social care managers, however staff were unaware of any action taken, to date, to address this.

5.9 The Nottingham University Hospitals NHS Trust children emergency department (ED) and the out of hours medical services electronic information management systems, ‘flag’ children and young people who are frequent attendees, and who are known to be on the child protection register, and /or where there has been known domestic violence within the home. The system does not record if the young person is a carer. Adult ED staff report that they are now asking for this information, however the process for further action is less clear. Unborn baby and the high risk pregnancy information alerts are also recorded on both the ED information systems, which ensures that maternity services are alerted of any attendance and can follow up the women. The information management system in ED does not record the names of the local children homes, which would be an indicator that a child presenting living at the addresses is looked after, and the need to ascertain who has consenting rights.

5.10 There is effective partnership working with ED, minor injuries, walk-in service and the out of hours general practitioner services, all of which inform primary care and community staff of the attendance of the a child or young person within 24 hours which is ensuring that follow up actions can take place in a timely manner and children are safeguarded appropriately.

5.11 Emergency care staff at Nottingham University Hospital NHS Trust have identified that there is a potential gap in service provision for those young people who present with disturbed behaviour, who do not meet the CAMHS criteria and whose parents are unwilling to take them back home. These young people are often left in ED, as this is seen as a place of safety; however this is inappropriate. Referrals to social care are not accepted as the young person, although now homeless and not in an approved place of safety, (as defined in the Mental Health Act) does not meet the social care thresholds, resulting in the police often arresting the young person, which is viewed as inappropriate by staff.

5.12 Looked after children (LAC) health staff, named nurses, health visitors and GPs all receive notification forms from ED and other unscheduled care settings, however it is recognised that those older looked after young people that attend adult ED settings, are not always notified to the LAC health team, and action is yet to be taken to resolve this fully. There are good ED liaison health visitors which ensure that the LAC team, health visitors and school nurses receive copies of the notification ensuring that the young person is followed up. General practitioners (in 25 practices), are able to identify and flag those children known to social care from families identified as being ‘in need’ on their electronic patient record systems. The system has the functionality to identify those children who are young carers; however this is not in use as onward processes have not been developed. Practices
are able, however, to identify those families where there are young carers, and ensure that needs are fully met.

5.13 Missing children, unborn baby alerts and high risk families’ notifications are now sent to unscheduled care settings with good joint planning to ensure that young people and families are kept safe, reducing vulnerabilities. Staff report good engagement and integrated working with both Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conferences (MARAC) meetings attending these as required ensuring good communication.

5.14 There have been good links with the local Royal Society for Prevention to Cruelty to Animals, (RSPCA) resulting in a number of safeguarding referrals being made following allegations of animal abuse and the alleged abuse of children.

6  Outcome 11 Safety, availability and suitability of equipment

6.1 Those parents and carers met during the inspection, whose children had disabilities, raised no concerns over the availability of medical loans or equipment. They reported a degree of satisfaction with the services.

7  Outcome 12 Staffing recruitment

7.1 All health staff interviewed confirmed that during their appointment that they had been subject to a criminal records bureau check.

8  Outcome 13 Staffing numbers

8.1 There has been recent recruitment to address the shortfall in health visitors, supported by both the health boards and the LSCB. The new recruits are currently taking up post. There has been, as a result, a skill mix review and cross training between school nurses and health visitors, although the take up has been poor. This shortfall, along with the shortfall in social workers, has caused some delays in the service redesign to the 0-19 year old teams, and co-location and integrated working with social care staff. There is no named GP in post (the role has been unsuccessfully advertised), some practices have lead safeguarding children staff, and the designated doctor and other named doctors are effectively covering the role currently. Succession planning for designated and named roles is at an early stage of development.

9  Outcome 14 Staffing support

9.1 There is a good range of training for all looked after children health staff that is well accessed. All LAC staff are C-card trained and are able to provide sexual health training, assessments and condoms during clinic sessions, which not only has improved the service for the young person but increased job satisfaction for staff.

9.2 There is good compliance with safeguarding training. A number of staff have attended targeted training, which had informed their practice. As yet the walk-in centre service provided by CitiHealth has to monitor effectiveness of training on practice.
9.3 Some general practices have had targeted practice based training sessions, complimenting the eighteen month protected learning time sessions. Due to the training the practice information systems, now have a direct electronic hyperlink to current safeguarding policies and procedures. This is ensuring that staff access the current document and follow the correct process, especially as some practitioners have not needed to make a referral for a number of years. Some practices have used this approach with their named and designated staff leading the session and all practice staff had attended, this had enabled them to review their local practice procedures ensuring that they are robust. There has been an increasing good rate of attendance from independent contractors to training, including those providing general medical and dental services.

9.4 The consultant/designated nurse for safeguarding and looked after children has carried out a systematic evaluation of how safeguarding training has changed and influenced practice. The evaluation to date shows that there has been improvement in health information sharing and an improvement in health professionals attendance at routine and emergency children in care meetings. This has resulted in professionals having immediate, up to date information which informs future decision making and enables them to address health concerns promptly. There is improved recording of health rapid response to, and escalation of, safeguarding concerns. Safeguarding concerns are increasingly flagged on the information management system in order that all health practitioners (including general practitioners) are alerted in a timely manner. Evaluation from general practitioner training shows that even though there is no named GP, there has been an improvement in communication and health assessment information for children in care, and closer scrutiny of information and signposting of issues to either safeguarding designated and named professionals or looked after children staff. Health staff were able to give individual examples where, as a result of training, they have been able to be more confident in their decision making. Further, a number of adult services staff reported that as a result of children safeguarding training they had made a number of referrals resulting in action being taken to protect the child.

9.5 There has been effective joint safeguarding referral training with children centre and family nurse partnership staff. Staff report that training has enhanced their understanding of each others roles and they have improved their referral forms, which are now electronic to improve access and legibility.

9.6 All staff interviewed have regular access to a range of supervision, and for health visitors, school nurses and midwives this is mandatory. The speech and language services do not have a structured process in place; individuals have sought supervision and found this to be of great benefit to their practice.

9.7 All staff working in the out of hours doctor services are trained in safeguarding to the appropriate level, with 605 trained in domestic violence (these staff may also be local GPs). The walk-in centre is showing a similar level of compliance with training. Within Nottingham University Hospitals NHS Trust children emergency department all staff are in date with domestic violence training and 80% of all staff (including reception and emergency department assistants) are level 3 safeguarding children
trained. All clinical staff have the appropriate paediatric resuscitation and children
pain assessment training.

9.8 General practitioners (GP) have noticed that communications with health visitors
has been reduced with the recent relocation of health visitors to children centres and
the good support and advice they were receiving on an ad hoc basis is now not
taking place, therefore limiting the sharing of local intelligence and concerns relating
to a family in a timely way. There was no evidence of other processes being used
apart from the ‘red card’ bi weekly/monthly meetings.

9.9 Effective ‘red card’ safeguarding meetings are held within general practices.
These meetings review the information sent from unscheduled care settings for all
children and young people who have attended (which is submitted on a red record
card) and a course of action with named professionals is agreed. This information is
uploaded on to the practice information system with a flagging system being used to
identify and monitor those families of high risk, child in need or child with a child
protection plan.

9.10 The team providing the target mental health provision in schools (TAMHS), with
27 schools, are providing accessible training in schools and to health staff. However
the evaluation schedule to demonstrate impact and effect on outcomes is yet to be
developed.

10 Outcome 16 Audit and monitoring

10.1 There are effective performance monitoring of both national indicators and a
range of locally identified indicators related to both the children and young persons
plan, looked after children, and the public health indicators such as emotional and
physical wellbeing, consent to treatments and especially consent for looked after
children health assessments, visual and hearing assessments.

10.2 NHS Nottingham City Board receives regular reports from all health providers
and takes appropriate action to investigate and hold providers to account where
there are concerns that their quality schedule assurance safeguarding action plans
are not being met. Each health provider board receives at least quarterly progress
updates; together these systems are ensuring that corporate action is being
effectively taken and monitored to safeguard children and young people.

10.3 Nottingham University Hospitals NHS Trust children emergency department
undertakes regular practice based audits and peer case file reviews, which has seen
an increase in appropriate safeguarding referrals and improvement in the quality of
record keeping.

10.4 All health providers and commissioners have completed the Section 11 audits
and have developed and are implementing action plans, (NHS Nottingham City was
fully met, the criteria at the time of the audit), which are effectively monitored by the
LSCB.

11 Outcome 20 Notification of other incidents
11.1 Health staff are aware of whistle blowing policies and procedures; however no staff interviewed during the inspection had had to use them.

12 Outcome 21 Records

12.1 All health records seen during the inspection complied with professional record keeping guidance.

13 Recommendations

Within 3 months

Nottinghamshire Healthcare NHS Trust and Nottingham City Council must ensure that referral status is effectively fed back to the referrer in a timely manner and that the health action plans for looked after children are updated accordingly in order that ongoing monitoring of emotional well being is effective.

Nottingham City Council and the looked after children and adoption health team at CitiHealth must ensure that the use of the Strength and Difficulties Questionnaires (SDQ) is fully embedded into the annual health assessments in order that full physical, emotional and mental health assessments take place.

Within 6 months

Nottingham University Hospitals NHS Trust and partner agencies must ensure that the gap in provision is addressed for those young people who present at the emergency department and who are homeless, in order to optimise their treatment and safety.

Health partners must ensure that there continues to be effective and efficient access to safeguarding health advice for general practitioners and other primary care workers in order that the absence of a named general practitioner does not adversely affect outcomes for children and young people.

Nottingham City Council with NHS Nottingham City must ensure that general practitioners are regularly updated on referral processes to children’s social care and are made aware of early intervention services, including CAF, and can receive general advice on all safeguarding matters.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt 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.