Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in LIVERPOOL	
Date of Inspection	**21ST February – 4th March 2011**
Date of final Report	**8th April 2011**
Commissioning PCT	**Liverpool PCT (5NL)**
CQC Inspector name	**Lynne Lord**
Provider Services Included:	**Liverpool Community Health NHS Trust (RY1)** **Alder Hey NHS FT (RBS)** **Liverpool Women's NHS FT (REP)** **Royal Liverpool and Broadgreen University Hospital NHS Trust (RQ6)** **Cheshire and Wirral Partnership NHS FT(RXA)** **Merseycare NHS Trust (RW4)**
CQC Region	**North West**
CQC Regional Director	**Sue Mc Millan**

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 .

LIVERPOOL	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Good
Contribution of health agencies to keeping children and young people safe	Outstanding
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Be Healthy	Outstanding

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:

Liverpool is one of five metropolitan districts on Merseyside with an overall population of approximately 442,300. Children and young people aged 0 to 17 years make up 19.3% of the population (85,500).

Planning and commissioning of universal, targeted and specialist child health services and primary care is undertaken by Liverpool Primary Care Trust (PCT). Health visiting and school nursing are provided by Liverpool Community Health NHS Trust, with children's community therapy services and the community paediatric medical team provided by Alder Hey Children's NHS Foundation Trust. The main providers of acute hospital services, including accident and emergency services for children and maternity services for children and families in Liverpool are Alder Hey Children's NHS Foundation Trust, Liverpool Women's NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospital NHS Trust.

Liverpool PCT commission child and adolescent mental health services (CAMHS) from Alder Hey Children's NHS FT who provides Universal, Tier 2 and Tier 3 CAMHS. North West Specialist Commissioning Team (NWSCT) commission Tier 4 CAMHS services from Cheshire and Wirral Partnership NHS FT on behalf of the Cheshire and Mersey PCT's. Merseycare NHS Trust provides transition into adult mental health services. Specialist treatments are also provided by Liverpool Heart and Chest Hospital NHS Foundation Trust, (the latter has not been visited during this inspection, but has been included in the focus groups contributing to safeguarding children's agenda).

A range of independent contractors are additionally commissioned by NHS Liverpool such as general practice, dental, optician and pharmacy services with the out of hours support provided for general practice by UC24. UC24 is a jointly commissioned out of hours GP service with Knowsley PCT with additional responsibilities for other NHS care providers in the area.

1 General – leadership and management

1.1 The contribution of health agencies to keeping children and young people safe is outstanding. There is highly effective practice across health that consistently contributes to improved outcomes for children and young people.

1.2 A well established children's joint commissioning framework with the local authority is in place. NHS Liverpool (PCT) has shown particular commitment and sustained investment in the safeguarding agenda, which has resulted in strong and effective safeguarding leadership within commissioning. Robust clinical governance, quality assurance and performance monitoring is undertaken with provider services. These are against the priorities agreed within both the Joint Children's Strategic Needs Assessment and the Children's and Young Peoples plan.

1.3 The partnership between the local authority, health and education has established robust systems and processes which provide coherence in respect of safeguarding provision across the city. This is based on a good knowledge of the needs of children and families and intelligence on service demands and pressures. It is creditable that leaders and managers are maintaining the levels of services to safeguard children and young people against significant demand.

1.4 The board of the PCT has robust frameworks in place to demonstrate the assurance of compliance within safeguarding, against both performance and quality targets. All executive and non executive members have undertaken level one safeguarding training and have received safeguarding children's resource packs. There is a non executive lead member who provides appropriate support and rigorous challenge for both health and safeguarding children agendas.

2 Outcome 1 Involving Users

2.1 User engagement and participation of looked after children (LAC) is excellent There is a well established and effective healthy care partnership group in place. Members are multi agency and multi professional from the PCT and local authority (LA). Membership also includes young people from the Children in Care Council (CICC) who demonstrate exceptional commitment and enthusiasm not only in improving their own health and well being, but also supporting and encouraging other young people to engage more with health professionals.

2.2 One leading success is a "drop in"- one stop health session, now held weekly at Sefton Grange, the base for the leaving care team. Members of the CICC attend, voluntarily, and work alongside health care professionals. General advice and support is given and they assist in signposting to other agencies. This was commenced after the CICC realised that young people were not accessing health guidance and support, particularly for sexual health and were unwilling or unable to travel to attend multiple venues to access services. A phone line has been requested within the drop in health venue so that appointments can be made directly for GP and dentists and this is currently being considered.

2.3 A number of special interest panels have been created as sub groups of the CICC and from meetings held throughout the year, a work agenda is created, which is led by the members. A publication "About You" has been produced by the CICC and the aim is to raise awareness of the range of social, health and voluntary services available for young people in care. It has recently been decided that this publication will now be made into a web site that can be constantly and easily updated and also will be able to demonstrate how many young people are actually accessing the site.

2.4 Annual training is provided for foster carers by the healthy care partnership to assist them when issues of sexual and other health matters arise. They are also fully informed of the range of health services available.

2.5 Engagement of young dads is excellent. There is an ante natal programme designed specifically for this group - "hit the ground crawling ", held in children's centres, within some of the most deprived areas of the city. The programme is facilitated by male staff members and by some of the young dad's themselves to support them to be more actively involved in the care of the new born babies. It has seen consistent attendance and active participation by all attendees.

3 Outcome 2 Consent

3.1 Within both the acute and mental health providers there are appropriate policies and procedures in place that ensure consent is taken prior to any treatment of children and young people. Consent is gained from Parents and Carers and is appropriately documented. The Gillick competency of young people is fully assessed within all services but particularly within sexual health.

3.2 Consent to undertake health assessments is obtained, in accordance with the Department of Health's Guidance, by the LAC health team. Consent is also obtained to the share the summary and health recommendations with social care and GPs.

4 Outcome 4 Care and welfare of people who use services

4.1 Integrated health visitor and school nurse teams have been developed across Liverpool. Caseloads are held of approx 300-400 families but this can vary. Caseloads are RAG assessed according to areas of deprivation and vulnerability of families. Teams are attached to either to GP practices or children's centres. There are vacancies in some teams, but there is active recruitment underway. Most confirmed that caseloads are generally manageable. The universal health programme is being delivered; within a risk based and skill mix approach. Health visitors are generating common assessment forms (CAF) and are lead professionals in most cases. The CAF Coordinator was cited as being effective in moving on CAF's to avoid drift. Referral thresholds are well understood and staff are aware of the recent refresh of threshold guidance. All report strong multi-agency and partnership work.

4.2 Good provision is in place for unaccompanied asylum seeker children (UASC) and traveller communities. A specialist health visitor is in post, who works closely with the Government Boarder Agency. Information about the dispersal of UASC is generally received in a timely manner of dispersal of UASC. This provides as much health information as possible, in regard to history, immunisation status and escalating any known immediate safeguarding issues. Interpreter services are available for a wide range of ethnic backgrounds and usually a community mental health worker attends the initial health assessment to escalate any mental health issues.

4.3 The traveller community has a permanent site within the Vauxhall area of the city. There is a good multi agency team in place that includes health, LA, social inclusion, designated education and CAMHS. Regular health sessions are held on the site. Accommodation for these had been an issue, but the use of a porta cabin has improved confidentiality. Travellers are usually well engaged with health services, but there have been some environmental issues, particularly in relation to the number of potential dangerous dogs kept, which has been appropriately escalated to the LA and Police.

4.4 Liverpool was part of Wave 2B of the Family Nurse Partnership (FNP) programme and are currently supporting 100 of the most vulnerable clients and their families, within some of most deprived areas across the city. Case studies clearly demonstrate that there are significant improved outcomes for babies, parents and the extended family. Smoking, drug use and high risk behaviour have steadily decreased, whilst the FNP team have seen an increase in the take up of breast feeding and improved engagement with women and their partners. The FNP are based in one children's centre and hold caseloads of up to 25 clients. There is a high level of joint working reported with housing, social care and voluntary sector.

4.5 School nurses are part of the integrated team with health visitors. Drop in sessions are well established in all secondary schools and are usually well attended. Sessions are also held in primary schools for parents/carers and this proves to be instrumental in enabling better engagement and signposting to appropriate services both within health, social care and housing. There is a good working relationship with family support workers from the LA. School nurses contribute to the sex and relationship education and PSHCE curriculum's and work closely with teachers and teaching assistants. Young people often remain on caseloads when they have entered further education to ensure continued health input, as young people are now commencing at community colleges at an earlier age.

4.6 There is excellent child and adolescent mental health services (CAMHS) provision across Liverpool. A range of specialist teams are commissioned, including early intervention, LAC, specialist education support and a 16-18 team. These are multi professional, multidisciplinary teams which include Clinical Psychologists, Psychiatrists, Mental Health Nurses, Family Therapists, Child Psycho-therapists and Mental Health Practitioners. An emotional wellbeing and CAMHS commissioning strategy has been developed in partnership with CAMHS and other community services providers including schools. This has resulted in direct work across children's services where children and young people have suffered physical trauma or acute / chronic illness, improved liaison with schools and community services and training staff in hospital and the community.

4.7 Waiting times for access to CAMHS are good at approximately 4- 6 weeks, with fast track access for LAC, within 24 - 48hrs. All referrals are screened via the single point of access system the Centralised Assessment and Brief Intervention (CABI). This provides a fast track to Tier 3 services determined by need and risk. Early assessment and signposting across range of multi-agency services is undertaken. To improve engagement and non attendance, a free phone appointment system with choice of date, time and venue is offered.

4.8 Early intervention by the Working Together team is outstanding. This is targeted intervention for 0-7 yrs with direct work with families at highest risk. There is joint working with Tier 1 professionals and in particular within the family nurse partnership model. Current initiatives include supervising the community mental health workers who are supporting parents with significant mental health problems, joint working with safeguarding teams and a programme to encourage parents to become co-trainers.

4.9 There are a range of effective education programmes in place from the CAMHS education support team. The team around the school model facilitates interventions including Webster Stratton parenting programmes, cognitive behaviour therapy groups and self esteem and resilience groups for teenagers. Transition groups are in place to support the most vulnerable children and young people through transition from nursery to primary and then onto secondary education. CAMHS currently link into 9 secondary schools. There is also specific provision for children and young people with learning or physical disabilities.

4.10 CAMHS outreach services are provided when a young person presents via the accident and emergency department (A&E) or walk in centres with substance misuse or self harm. A follow up brief intervention clinic is available within A&E at Alder Hey, which offers support and signposting, into services such as Adaction and Young Adaction within one week of the initial attendance
Any person who does not attend the service after discharge is followed up quickly. There is effective liaison with social services and if applicable, the LAC health team.

4.11 For young asylum seekers, refugees and ethic minority groups there is a dedicated service – Haven. This provides a range of mental health support and guidance for these hard to reach young people. There is now improved liaison with the team of community development workers and they provide support and training for mainstream services. Work within specific schools is seeing improved outcomes and by collaborative working improving accessibility and acceptability for these young people.

4.12 Transition is managed well by the Tier 3 16-18 team service. There is effective interagency work on going with LA, education, housing and connexions. Links with adult mental health services are good via robust transitional protocols and early implementation of the Care Programme Approach. Care pathways with voluntary organisations are also in place. Advocacy workers are new in post within Alder Hey hospital and are linked with the Liverpool Advocacy Hub. This will contribute to continuing to improve transition into adult services for young people. The adult mental trust is well engaged with the children's safeguarding agenda and has regular liaison with both the safeguarding and the CAMHS teams. This ensures that both child and adult dependants of any adult with mental health disorders is always identified and any concerns can be escalated to the appropriate agency. Attendance at core groups and case conferences is good.

4.13 There is effective provision to improve the health of and support children and young people with learning or physical disabilities. There is evidence of strong multi disciplinary and multi-agency working to deliver holistic care packages, both within the home, mainstream schools and the 8 special schools across Liverpool. Agencies such as education, LA and health work well together to improve outcomes for these children and young people. The Disabled Children's Team uses multi-agency health action plans to support children. A new tool for planning and reviewing needs has been developed. There is a dedicated safeguarding specialist nurse in post, who ensures close working and communication with the designated leads and clinical staff. Regular "Team around the Child" meetings are held and attendance is reported to be good from all agencies involved.

4.14 A one stop shop has been implemented that ensures that parents and carers of children and young people with disabilities have improved access to health and social care professionals.
The “Aiming High” agenda has facilitated improved access to a wide range of leisure activities that include cycling, basketball, dance and swimming. Provision for respite care is good. This is mainly commissioned from 3 children’s hospices. Respite care is agreed by the Short Break Panel, which has representatives from health, LA, education, private and voluntary sectors.

4.15 The CAMHS community mental health team is a key partner in the team around the child within this service. All children’s centres are currently running a sleep service, which has had a massive impact on children under 5 and their parents or carers. Weekly sessions are held and this has resulted in fewer referrals into CAMHS due to interventions that see improvements in the behaviour of the children and a reduction of the stress and pressure for the parents and carers due to sleep deprivation.

4.16 The speech and language therapy service (SALT) is acknowledged as having high waiting times, currently at 50 weeks from referral to treatment, but having seen a reduction from over 80 weeks. The PCT and LA have committed joint investment that has enabled 5 additional therapists to be successfully recruited, with commitment for further recruitment from April 2011. A report on the impact of investment into the service was presented to the PCT board in early February. Despite these issues early intervention has been effective with focussed work within schools, children’s centres and other early year’s settings. Staff are trained across the range of locations to recognise the difference between delay and disorder and potential speech and language issues. As a result the service is seeing more appropriate referrals for more specialist interventions.

4.17 The quality of the health assessments for LAC reviewed during this inspection are good. Initial health assessments are always undertaken by Designated Doctor or community paediatrician. There is also health promotion input from the link nurse within the LAC health team, to ensure a holistic health review. Assessments are carried out by the lead health professional and are undertaken within statutory timescales. Additional clinics have been commissioned to increase capacity. Currently an audit is on going to establish the waiting times between a child or young person becoming looked after, the LAC team receiving the request for initial health assessment and the actual assessment date. Health care plans are in place, with appropriate follow up of agreed health appointments for dentists, opticians, speech and language and other specialist appointments such as CAMHS. When LAC do not arrive for appointments, these are robustly followed up.

4.18 For LAC placed out of borough health assessments are undertaken by the authority undertaking the placement. Notifications of assessments due are sent and health care plans and copies of the assessment are received. Assessments are undertaken for those LAC placed in Liverpool from outside the area and these incur a tariff charged to the placing LA. An appropriate data base is maintained to track the flow of LAC.

4.19 The availability and provision for the full range of health care for LAC is very good. LAC have fast track access into CAMHS services, with particular support from dedicated LAC CAMHS workers. The Strengths and Difficulties screening tool questionnaire is use to assess emotional and mental health of LAC, and this is undertaken at initial and then repeated at review assessments. This ensures early recognition of potential mental health issues and more timely interventions.

4.20 There is good partnership working across health to support LAC in accessing sexual health services, the substance misuse service Addaction and joint working with the YOS. There is a dedicated teenage pregnancy midwife who works closely with LAC who become pregnant. Currently there are 5 young women who are pregnant, 3 from out of the authority and 2 having given birth recently. Appropriate interventions are in place to advice on future contraception, with good uptake of LARC.

4.21 There is a wide range of effective sexual health services across Liverpool. There are multi-agency, multi professional services with strong partnership working between the PCT, independent and voluntary sectors. Access to services across the city is very good. Drop in sessions are offered from 17 various locations and are available Saturday and Sunday. There is also a dedicated young person's clinic which enables holistic health advice and support to be easily accessed. These include Abacus and Brook who offer a full range of sexual health advice, contraception and treatments for all age groups. Armisted offers support and signposting for lesbian, gay, bi and transsexual young people. Sahir House is a multi cultural support and advice centre offering help for young people who have been diagnosed or are living with someone with HIV.

4.22 Young people are well engaged with drop in health sessions in secondary schools and further education colleges. Male education workers have seen improving attendance and engagement with young males. There is an enhanced service provided within 5 schools in identified as "hot spot" areas, within the most deprived areas of the city. There is very good uptake of contraception services including LARC. There is excellent engagement with education and the sexual health outreach team work closely with the school nurses and teachers to improve the SRE and PHSCE curriculum. Health days are frequently held in all secondary schools with joint work with the healthy schools team.

4.23 Young people with learning or physical disabilities and their parents or carers also receive appropriate support in regard to sexual health issues. Targeted work is undertaken within the main stream, special schools and residential placements. A domiciliary service is also provided, with specific sexual health advice leaflets designed for these young people.

4.24 The rate of conceptions for under 18 yr olds has seen a decline since the baseline rate in 1998 by 8% and has remained steady. Targeted work is in place to avoid second pregnancies with Brook and other sexual outreach programmes. The teenage pregnancy board robustly monitor performance not only of the teenage pregnancy strategy but also performance against agreed contracts and service specifications around safeguarding.

4.25 If any young person under 18yrs becomes pregnant there is good support from a designated teenage pregnancy midwife. These girls are also encouraged to join the family nurse partnership programme. Agencies work very well together, with support available from social services, voluntary sector and dedicated education inclusion programmes. Drop in ante natal clinics are held within both children centres and the women's hospital and these also link with a dedicated clinic for girls and women from other ethnic backgrounds. Parenting projects, such as "hit the ground crawling" and "baby fast" are well established and have excellent engagement from young dads and the extended family.

4.26 Pre - birth plans are formulated with the appropriate partner and agency input so that the most vulnerable have jointly agreed care plans once in labour. Pre-birth plans are inputted to the electronic patient record within 48hrs of agreement. The safeguarding database also ensures that information is readily available about individuals were there might be a concern. A well established safeguarding group within women's health ensures that safeguarding is a priority throughout clinical practice. Membership includes the teenage pregnancy midwife, domestic violence midwife, peri natal mental health and named midwife.
The Enhanced midwife role has been key in engaging more hard to reach young girls who are pregnant, many of whom are sex workers and are most vulnerable due to long term drug or alcohol misuse. Targeted work is on going with this group. Various levels of safeguarding concerns have been disclosed and the appropriate services have been able to offer support due to the relationship and engagement built up by this midwife.

5 Outcome 6 Co-operating with others

5.1 Partnership work across health, education, social care and the voluntary sector is excellent. There are numerous projects, initiatives and care pathways that are joint funded, multi agency and multi professional. The safeguarding agenda is clearly a priority. Cross sector work is well embedded within the DAAT, YOS, community, acute and mental health providers.

5.2 There is appropriate membership from all health trusts on the Liverpool Safeguarding Children Board (LSCB), its sub groups and the Children's Trust. Within health the leadership from the independent chair of the LSCB is cited to be enabling improved collaboration with partner agencies. There are numerous examples of changes to practice following the dissemination of learning from serious case reviews (SCR).

5.3 The PCT has a dedicated equality and diversity commissioner post which ensures that equality, culture and diversity are appropriately considered when commissioning a range of services and specialists projects. These have included access to the healthy start vitamin programme to prevent rickets in Somali children and young people, agreement to perform circumcisions for religious needs, a dedicated worker to support females who have suffered from or are in danger of genital mutilation, who works very closely with secondary schools and a full time sickle cell and thalassiemia nurse. Also a total of 16 health link workers have been appointed to work across Liverpool, with both health professionals, social services and voluntary groups to provide support and guidance for BME communities. Cultural competency training is also a requirement within service level agreements or contracts and self assessment tool kits are completed by each service to assess compliance with the agreed assurance framework.

5.4 There are excellent examples of the contribution that voluntary sector agencies make to safeguarding. “Sanctuary” offers invaluable support for carers of children and young people, whose parents are deceased or have been significantly affected by substance misuse or domestic violence, in the most deprived areas of the city. In many cases this results in children able to remain with grandparents rather than entering the care system.

5.5 Work to support LAC who are leaving care is excellent. The link nurse within the LAC health team is co-located with the LA leaving care team 1 day per week. This effectively targets work with care leavers who are age 16 and above. This co-location has led to improved co-working and more rapid response to the needs of young people. Health summaries are being produced to enable a comprehensive health history to be appropriately documented and accessible.

6 Outcome 7 Safeguarding

6.1 Strong leadership and support is evident from the designated and named professionals within the PCT and all provider trusts, including the Named GP. This is supported by well established safeguarding assurance groups across health, with vigorous performance monitoring of safeguarding issues. All provider hospitals are active members of the safeguarding groups and this ensures appropriate communication, discussion and escalation of concerns to the correct agencies, in a timely manner. Annual reports are sent to the designated nurse from all provider trusts and are collated into the annual PCT report. This details all safeguarding activity, training, supervision and monitoring of action plans from SCR’s and common assessment framework activity. Policy and procedures for each organisation are scrutinised and are ensured to be current. The designated nurse is a joint appointment with NHS Knowsley and has been in post since January 2011. To date this arrangement is working well and is being viewed by the Strategic Health Authority as a possible practice model , considering future restructures and reorganisations of PCT’s across the North West.

6.2 A model of excellent practice was observed within a large GP practice in Aintree Park. A bespoke, stand alone safeguarding web package has been implemented by one of the GP's, following learning from a SCR. In addition to an alert flag, this documents all information for every child or young person with child in need, child protection or safeguarding concerns. Information is entered live during case reviews, at the monthly safeguarding meetings that include all the GP's, practice manager, receptionists, advanced nurse practitioner and health visitors. Information is also shared from other health professionals, such as school nurses, midwives, social workers or any other relevant agency.

6.3 There is a well established child death overview panel (CDOP), with good examples of how recommendations from reviewed cases have been implemented in practice. These include safer sleeping protocols and a hub and spoke bereavement model introduced to assist professionals, as well as Parents and Carer's when dealing with a child's death. The CDOP has effective health representation from across the PCT and provider trusts and the partnership work across education, LA and health is excellent.

6.4 The safeguarding service delivered at Alder Hey Hospital is an exemplar in clinical practice. Safeguarding is extremely well embedded throughout all wards and departments. Excellent examples of how safeguarding is entrenched in all practice was noted not only in clinical areas such as wards and PICU but in X-ray and within the medical photography department. There is outstanding and committed leadership from the executive leads, designated doctor, named leads and in particular the consultant nurse for safeguarding. All patient documentation has safeguarding criteria that that is robustly completed. There is a wide range of information for young people, parents and carers that signposts into support services across health, social care and education in regard to safeguarding, health and general wellbeing. As a specialist children's hospital there are frequent admissions from across not only the North West region but nationally. Detailed transfer sheets ensure that any safeguarding issues are quickly recognised and escalated both locally and with the placing organisation.

6.5 The Rainbow Unit for children and young people who have been subject to sexual or physical abuse is excellent. The environment has been recently improved to ensure that the child's or young person's journey throughout is undertaken in a safe and protective environment. This, not only reflects the requirements of forensic investigation, but also maintains sensitivity of the needs of the individual, parents and carers. The centre is the regional SARC unit and deals with many referrals from outside the city. Any safeguarding issues are immediately recognised and escalated as appropriate.

6.6 GPs are well engaged with the safeguarding agenda. Flagging systems are available in most practices across Liverpool and all have an identified safeguarding lead. Each practice is working closely with the named doctor to ensure that all GP have attended safeguarding training. 93% of independent practices have undergone training, the rest of the practices have 100% training at either level 2 or level 3. Notifications are received from the A&E department and walk in centres when any child attends. Safeguarding awareness is consistently raised within a monthly GP bulletin which is e mailed to all practices.

6.7 The dental governance lead within the PCT has undertaken inspections of all dental practices from 2009 and within the assurance framework did identify some practices were safeguarding training had not been undertaken. Since 2009 there has been a marked improvement in attendance at training, with links to the Mersey Deanery and now all practices have an identified safeguarding lead. Inspections are carried out annually. Safeguarding training has been specifically modified to ensure that it pertains to dental health and neglect and other safeguarding issues related to dental practice. Any concerns were dental neglect is noted or there are missed appointments, the health visitors or school nurses are alerted. Dentist are aware when a child or young person is looked after , due to checking consent prior to treatments, so any concerns can be raised with the LAC health team.

6.8 Multi-agency risk assessment conferences (MARAC) are well established with good attendance from health and a wide range of agencies. Midwives regularly attend meetings and sharing of safeguarding information is well facilitated. Agencies value the opportunity to share information, agree action plans and monitor progress. MAPPA arrangements are good and oversee high risk cases including offenders due to be released from prison who may pose a risk to children and young people

7 Outcome 11 Safety, availability and suitability of equipment

7.1 Emergency care for children and young people is delivered in the A&E department in a safe environment within Alder Hey Children's Hospital up to 16 yrs of age. An effective tracking system is in place that alerts staff to any child protection (CP) or safeguarding issue. All attendances are tracked and copies of assessment sheets are forwarded to health visitors, GP, school nurse or social worker if applicable. Anyone who does not attend for any follow up appointments are tracked by the named nurse. From arrival, through triage and then examination and treatment, child protection and safeguarding prompts are required to be completed at every stage. If a child or young person is noted as having any concerns, the examination is always undertaken by senior medical staff.

7.2 Within the A&E at Royal Liverpool Hospital children who are under 16, when presenting are triaged and then are transferred to Alder Hey Hospital. For those 16 yrs and over there are effective safeguarding procedures in place, with health visitors, school nurses and GP informed of all attendances as appropriate. The named nurse also keeps duplicate cards of all attendances by anyone under 18yrs so tracking is robustly monitored. There is innovative work on going with secondary schools, lead by a nurse clinician. He is delivering workshops to young people on the long term impact of knife crime, for not only on the victim but the extended family. This is as a result of the numbers previously treated with knife wounds and joint work with the youth offending service. This work has been nationally recognised as a leading example in deterring knife crime.

7.3 There is a dedicated children's walk in centre located in the Smithdown area. There are effective safeguarding procedures throughout the centre. Alerts are flagged on the system of CP and safeguarding issues and multiple attendances at any of the additional walk in centre locations can be tracked and raised to investigate further. Notifications of all attendances are sent to GPs, health visitors and school nurses within 24hrs of attendance.

7.4 It is reported that there are no issues with procurement of equipment within children's services or the A& E departments of the Acute Trusts.

7.5 Equipment provision for disabled children and young people is good. Procurement processes via joint commissioning frameworks and Aiming High funding has meant that equipment is generally available when required from the central community equipment store.

8 Outcome 12 Staffing recruitment

8.1 Safeguarding is clearly embedded in the culture across health and included in all areas of recruitment and selection, induction of staff and ongoing training and development.

9 Outcome 13 Staffing numbers

9.1 No issues in regard to staffing establishments were raised during any interviews. There are a number of vacancies within health visiting but there is proactive recruitment on going.

10 Outcome 14 Staffing support

10.1 Effective training strategies have been developed by the PCT and all provider trusts. Staff attend not only mandatory training within their own trust but multi-agency training via the LSCB and the NSPCC. Good performance monitoring of attendance at safeguarding training is undertaken. Policy and procedural guidance for safeguarding is current and is readily available to staff via the intranet or via hard copies.

10.2 Staff have good access to supervision, via a variety of forums - individual, peer and group and there is appropriate evaluation of supervision to improve and influence clinical practice.

11 Outcome 16 Audit and monitoring

11.1 There is a review of performance monitoring within the LAC health team, with a new dashboard for performance being implemented from April 2011. Current performance is good with over 90% of initial and review assessments and immunisations completed to date. There is also a regional audit underway lead by Cheshire and Merseyside Child Health Development programme looking at the quality of initial assessments. This commenced in September 2010 and will be completed September 2011.

11.2 The LSCB is robust in auditing the work of agencies and their compliance with action plans arising from serious case reviews. There is a good system in place for multi agency auditing of common assessment framework, team around the child and team around the school performance.

11.3 Multiple audits are undertaken within the PCT and provider trusts that ensures rigorous monitoring of the quality and performance of safeguarding across health.

11.4 The Strategic Health Authority lead for children, young people and maternity reports good commitment and shared responsibility across the health economy in the promotion and performance of safeguarding. Section 11 audits are completed and these are appropriately monitored through designated safeguarding lead professional meetings

12 Outcome 20 Notification of other incidents

12.1 There are satisfactory arrangements in place across the PCT, acute and mental health trusts to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC.

13 Outcome 21 Records

13.1 Case files of looked after children are maintained in good chronological order. No electronic records are in use. All files examined demonstrate effective and timely information sharing between health and social care. LAC reviews were evidenced in all files. All LAC have lead health professional identified – this can be a health visitor, school nurse or link nurse from the LAC team dependant on age.

13.2 All files examined indicated that LAC are registered with GPs and dentists. There is good evidence on file of communication to the LAC health team and social care when a child or young person attends A&E, urgent care or walk in centres and for any unscheduled attendance at drop in sessions.

14 Recommendations

There are no recommendations for improvement to be made

Next steps

No action plan is required from the commissioning PCT following this inspection. Future compliance will be monitored via the regional team.