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

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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:

_Brighton and Hove has 54,700 children and young people under the age of 19 years. This is 21.5% of the population. The proportion entitled to free school meals is 17%. Children and young people from minority ethnic groups account for 26.3% of the 0-19 population, compared with 16% in the city as a whole. The proportion of pupils with English as an additional language is 9% compared to 13.8% in England. The city has a high proportion of students and lesbian, gay, bisexual and transgender residents. Brighton and Hove is also a destination for migrants from other parts of Europe with 15% of the city’s population born outside England, higher than for the region and for England. The city is the 79th most deprived local authority area as assessed by the index of multiple deprivation, with 22% of children classified as living in poverty. There are high levels of health inequality including life expectancy, cancer and circulatory disease, and smoking. There are also high rates of mental ill-health, alcohol and substance misuse and domestic violence._
There are 75 primary schools, nine secondary schools (including one academy and one school with confirmed academy status from September 2011), five special schools, two sixth form colleges and one further education college. At the time of the inspection there were 486 looked after children and young people. 30% are under five years of age, 78% are under 15 years of age and 22% are 16-17 years of age. The council and its partners support 186 care leavers.

The level of demand for services varies across the city, broadly reflecting patterns of deprivation and inequality and variable concentrations of families living in the different neighbourhoods. Brighton and Hove’s Children and Young People’s Partnership is led by the Children and Young People’s Trust Board (CYPTB) and an Executive Group known as the Chief Officers Group. A wide range of agencies are involved including the council’s children’s services, with cross party representation of elected members, the NHS Brighton and Hove City PCT, Sussex Community Trust (SCT), Brighton and Sussex University Hospitals NHS Trust (BSUHT), Sussex Partnership Foundation Trust (SPFT), general practitioners (GPs), the Local Safeguarding Children Board (LSCB), four representatives from schools and colleges, the police, the Voluntary and Community Sector (VCS) Forum, and Job Centre Plus. The city’s Youth Council and the Parent’s Forum each have a representative on the Board.

NHS governance is managed through the Head of Nursing and Governance. Hospital services including accident and emergency (A&E) services for children and acute maternity services are provided by the Brighton and Sussex University Hospital Trust. Children, young people and families access primary care through one of 47 GP practices and a walk-in centre. CAMHS in Brighton and Hove are commissioned and delivered through an integrated care pathway with a single point of referral. There are a number of organisations involved in service delivery across the tiers of provision:

- **Tier 2 community services** are delivered by a partnership arrangement between the council’s children’s services primary mental health workers and family support workers employed by two VCS organisations.

- The **Tier 3 clinical CAMHS service** provided by the SPFT includes input into a number of multi-agency teams e.g. substance misuse, youth offending, specialist child protection as well as clinic based provision.

- **Tier 4 inpatient and urgent help service and a transitions service for 14-25 year olds** are provided by the SPFT.

  In addition the SPFT provide specialist Tier 2 and 3 input to the Child Development and Disability service, there is a specialist service for looked after children and young people and children and young people with attachment difficulties, and VCS providers deliver a range of counselling, advice, advocacy and participation services. (Ofsted 2011)
1 General – leadership and management

1.1 The contribution of health agencies to keeping children and young people safe is good.

1.2 The PCT plays a key part in setting and achieving the overarching priorities of the Children and Young People’s Partnership, which include safeguarding, early intervention, participation, equality and diversity and shared vision, value and language. The PCT itself has a priority of reducing health inequalities, including a number of core strategies such as teenage pregnancy and alcohol and youth crime, all with action priorities, timescales and responsibilities. There has been a significant drop in the teenage pregnancy rate this year.

1.3 Partnership work is highly effective supported by good joint commissioning arrangements and joined up work with the Children’s and Young People’s Trust (CYPT) and the Local Safeguarding Children Board (LSCB). NHS Brighton and Hove City PCT is fulfilling its statutory safeguarding requirements with designated professionals in post supported by named professionals in all provider trusts. This includes an independent Domestic Violence Advisor who works out of the accident and emergency (A&E) unit at the Royal Sussex County Hospital which is effectively promoting the safety of children and young people. Staff at the new Royal Alexandra Children’s Hospital and in particular, the named nurse, doctor and midwife have raised the focus of child protection across the trust.

1.4 Engagement and relationships between health service partners and children’s services are very effective, with clear policies in place and good systems for referral, information sharing and understanding of partners’ capacity and contribution.

1.5 The LSCB health representatives are at an appropriate level of seniority to ensure an effective contribution to strategic decision making within both the LSCB and their own organisations. Health care workers provide very good services that ensure the children and young people of hard to reach and vulnerable groups are protected, for example the travelling community.

1.6 There are appropriate arrangements with all child deaths being notified to the named nurse and named doctor who consider whether there are any child protection concerns raised by the death. A named GP has been appointed by the PCT. There is an increasing level of attendance at safeguarding training by GPs and their practice staff with the majority of practices having received level three safeguarding training. However, monitoring of safeguarding activity within general practice is at an early stage and GPs who spoke with inspectors report that they do not feel they have a key role or have a significant contribution to make in child protection. Some GP’s and other healthcare professions report poor communication with children’s social care services.
1.7 Children’s centres are led by health visitors and provide a range of innovative and effective services with targeted provision for vulnerable and hard to reach families. Parents who spoke with inspectors report that this is improving access to services. Child protection case conferences are well attended by health professionals, including staff working with parents who have mental health problems. Staff who spoke with inspectors said they feel their contributions are valued and that they are helping to contribute to the decision making process. Information sharing is a strong feature of the emergency care settings with highly trained paediatric emergency nurse practitioners as the first point of contact. There are appropriately trained staff and clear procedures to recognise and assess children and young people at risk and a flagging system has been introduced to identify children and young people presenting who are the subjects of a child protection plan.

1.8 Services to promote the health and well-being of looked after children are outstanding. There is highly effective joint working and information sharing across agencies and targeted support. Rigorous monitoring and targeted work ensures that the health outcomes for children living in the city and those placed in other areas are consistently good. This is primarily due to the proactive and highly effective designated looked after children’s health team. Health outcomes for looked after children are better than similar areas. Performance on the proportion of looked after children and young people who receive their immunisations and receive a routine health assessment is very good at 94.2%. There is also excellent performance on dental health with over 90% of looked after children and young people receiving a dental health examination each year. There is excellent performance in the take up of health assessments by 16+ young people with 90% completion. All looked after children and young people are registered with a GP. Initial health assessments are of good quality, comprehensive and are used effectively to inform health care plans for each child or young person. There has been a sustained approach to improve the quality of health records over time and the quality of assessments sampled for this inspection are at least good.

1.9 There are examples of highly effective, targeted health promotion activity which takes place on a one-to-one basis during health reviews which is making a real difference to young peoples lives. For example, the excellent sexual health and contraceptive advice services provided at numerous outlets across the city and particularly from the 16 -18 nurse specialist. There is good take-up of these services which has contributed to the low conception rate by looked after young people. Also the 16+ nurse has a good understanding of the diverse needs of young people including specific needs of young asylum seekers which is ensuring their needs are met very well.

1.10 The Royal Alexandra Children’s Hospital (RACH) opened four years ago as part of the Brighton and Sussex University Hospitals NHS trust. It provides comprehensive acute paediatric care for children to a very high standard. From 1st April 2011, all infants under twelve months of age presenting at the accident and emergency unit will be seen in the specialist children’s assessment unit (CASU) within the RACH. Further plans are in place to develop this service so that all children are seen in the children’s hospital and come under the immediate care of paediatric staff.
1.11 The appointment of an energetic, high profile named nurse, doctor and midwife have raised the focus of child protection across the trust. The safeguarding professionals in each organisation work closely together and have a strong joint commitment to ensuring the safety of children and young people across Brighton and Hove.

2 Outcome 1 Involving Users

2.1 Involvement of children and young people by health partners by the PCT and provider trusts is good. Many professional groups such as midwives and health visitors use the interpreting services that are readily available to ensure people who use English as an additional language have access to healthcare services that meets their needs and reduces isolation.

2.2 Innovative and accessible sexual health services for young people are provided by a range of partners across the city and there is good take up of contraceptive and screening services. Sexual health services have been reviewed by young 'mystery shoppers' and the findings used to drive improvements with providers.

2.3 Feedback from mental health services is sought by the use of postcards and satisfaction surveys. There are established advocacy groups that inform how the service is developed.

2.4 Young people have input into mental health commissioning and service design through the participation group ‘Mind Me Up’. This group gives a voice to young people who have used services to meet with commissioners and provide user feedback.

2.5 The ‘Time Out’ parents group provides a resource and support for parents of children with autism. It uses the Positive Parenting programme as a basis but goes further than behaviour management advice by facilitating support groups, and signposting to other services.

2.6 Parents of children with disabilities are represented on the Strategic Partnership Board by an elected member of the AMAZE parents council. The partnership charter includes a commitment to representation and participation. Work with the parent partnership ‘Aiming High’ has led to improvements and redesign of short break services for families with a disabled child.

2.7 Outstanding support for children with disabilities and particularly those with complex health needs has seen an increase in the numbers of children being enabled to access mainstream education. Training and support is provided for school staff with input from a range of professionals including school nurses, physiotherapists, speech and language therapists and occupational therapists. Training for youth workers has enabled more young people with special needs to access mainstream leisure and youth services. The Compass leisure card, which is also available to looked after children, allows free access to leisure facilities around the city and encourages participation in positive recreational activities and sport.
2.8  The looked after children’s pledge has been produced in adapted format for children with disabilities. The complaint leaflet has also been adapted to provide a more user friendly version that enables young people with disabilities to be more involved in how services are provided.

2.9  Parents of children with disabilities are involved in staff training and provide staff with a perspective on how it is to be a family with a disabled child. Child branch student nurse training has a module on children with complex needs that incorporates a full session on the parent’s perspective.

3  **Outcome 4 Care and welfare of people who use services**

3.1  Procedures to inform community health professionals of attendances by children and young people at A&E are excellent with pathways in place for referral to substance misuse services and this is a model of good practice. The casualty cards of all children and young people under 18 years who attend the Children’s Assessment Unit (CASU) or A&E department are subject to a triple scrutiny that negates the possibility of any child protection concerns being overlooked and ensures timely referrals are made to other agencies. Pre-birth conferences are not always arranged in sufficient time for plans to be put in place before mothers give birth to their baby, leaving staff on the delivery suite and postnatal ward uncertain about whether to discharge the mother and baby.

3.2  A virtual ‘failure to thrive’ team has been established and protocols developed to ensure a multidisciplinary approach to the care of these infants which includes health visitors, acute paediatricians, CAMHS, and specialist health visitor and nursery nurse input.

3.3  There are highly effective services to support looked after young people who misuse substances through the RU-OK team. This ensures access to services is timely and responses are sharply focused to meet the individual needs of young people. The substance misuse team also provides training and support to foster carers which is well received and is helping to sustain young people in their placements. There are also specific specialist programmes to target hard to reach looked after young people who misuse substances through the Therapeutic and Psychological Access Services to tackle persistent and serious substances abuse. There is good provision for detoxification assessment and treatment programmes for looked after mothers of babies born with narcotic addiction or withdrawal symptoms. Young people in receipt of substance misuse services who spoke with inspectors were very positive about the support they receive.
3.4 The designated doctor for looked after children and young people is an appropriately senior community paediatrician. This ensures looked after children and young people are prioritised and often fast tracked to services from this single point of referral. The arrangements for referrals to CAMHS for looked after children and young people including those adopted or placed for adoption is very good. Every child and young person has a generic assessment within four weeks and there is 100% compliance with this timescale, with treatment promptly provided. The CAMHS learning disabilities team provide good direct support via the integrated care pathway, providing good advice to schools and carers. They also form an integral part of the multi-disciplinary team for looked after children and young people with disabilities and mental health problems.

3.5 Looked after children and young people with learning difficulty and/or disabilities are provided with outstanding ‘wrap around’ care from the disabled children’s team. This is supported by an effective and very well received key worker system that provides families, including foster families, with advice and support and co-ordinates the care package for individual children and young people. The AMAZE project is an exemplar of good practice for families with children with special needs. Parents who spoke with inspectors at the project reported that there is good take-up of services early, including respite care, by parents who are experiencing isolation, stress and anxiety to prevent family breakdown and the need for children with special needs to enter the care system.

3.6 Health visiting and school nursing services work extremely well with other agencies across the partnership and the co-location of services within the children’s services is a real benefit. The Healthy Child programme is being fully implemented for under fives through a casemix team, with specially trained family support workers carrying out routine interactions leaving Health Visitors free for more complex cases. There are good monitoring and review systems for children who are causing concern, and feedback/evaluation of the health visiting and school nursing service has been good. All schools within the Brighton and Hove City Council area have achieved Healthy School Status. Drop in clinics are held by school nurses in all schools with a good reported take up of this service. Sexual health drop in clinics are held in seven of the nine secondary schools to provide advice and support to young people. A breastfeeding co-ordinator works out of the children’s centres and provides professional support. A peer support system is also in place.

3.7 The general comparative health indicators for looked after children are very good in some important respects. For example, 94% of children have up to date immunisations (83.9% in England). A further 90% had their teeth checked by a dentist (86.4% in England) and 94% had their annual health assessment undertaken in the previous 12 months (85.4% in England). Performance on all these measures is better than the national average. All of the looked after children aged 5 or younger had up to date development assessments. Across universal services, immunisation rates have improved and at the time of inspection were predicted to make the 95% target. The looked after children’s health team are tenacious and very proactive in ensuring children are vaccinated. Court orders have been sought where parents refuse consent to immunisation on younger children and older children are targeted through school nurse ‘catch up’ clinics. Impressively, there was over 90% uptake of health assessments for looked after children aged over 16 years.
3.8 Looked after children are appropriately prioritised within the child and adolescent mental health service and the quality of service is good. Looked after children who receive a service express mixed levels of satisfaction, however those spoken to were all very positive about the less formal ‘TAPAS’ service. The Teen to Adult Personal Advisory Service, set up two years ago has been developed in response to an identified need. It ensures hard to reach young people, young asylum seekers, and those who have rejected support from CAMHS are encouraged back into mainstream provision through a combination of advice and direct practical assistance. The TAPAS staff work out of the youth hubs and provide a drop in facility. There are specialist BME and LGBT TAPAS workers in post. TAPAS also works with young people in a wider age range than CAMHS, providing services for young people aged from 14 years to 18 years, at a time when they are identified as being particularly vulnerable to rejecting mainstream services.

3.9 There is a single point of entry for all referrals to CAMHS services. All referrals are triaged at the twice weekly multi disciplinary meetings. Looked after children are automatically considered tier three and are prioritised within the service. All children have their first generic assessment (which can be up to three sessions) takes place within 4 weeks of referral. There is 100% compliance with this target. Some further assessments may take place whilst care plans are created and prior to treatment programmes commencing within 14 weeks. There is no waiting list currently.

3.10 CAMHS for children placed out of the area are not provided by Brighton and Hove health trusts, but contact is made with the receiving team where ever possible to support the needs of these children. The SPFT is the provider of CAMHS across the two neighbouring counties and this coupled with Brighton City Councils commitment to accommodating children within the city or a 20 mile radius wherever possible facilitates continuity of care.

3.11 The CAMHS learning disability team provides an integrated care team for children with all levels of learning disability. Services include counselling, family therapy and access to a psychologist.

3.12 Functional Family Therapy was set up initially as a research project jointly with the University of Sussex, aiming to prevent children on edge of going into care from actually going into care. This project has been so successful that is has now been commissioned for 2011/2012 and with clear evidence that this intervention provides value for money.
3.13 There are very good arrangements in maternity services for identifying and managing women who need additional support provided by specialist midwives. Two teen midwives are employed who provide antenatal and postnatal care to young women under 19 years of age who are pregnant. They accept self referrals or referrals from other professionals such as health visitors, social workers, school nurses or the Youth Offending Service. There were 73 girls delivered last year, with their support. The teen pregnancy service has received a Best Practice Award for antenatal care of vulnerable women under the age of 20 years. The Tarner children’s centre was judged Outstanding by ‘Ofsted’ with specific mention of the work being done with teenage parents. If a girl under 16 years is admitted to the maternity unit, a parent or guardian is permitted to remain with them at all times, as they would be in the children’s hospital. Young women aged between 16 and 18 years on admission who requested a parent stay would be considered on an individual basis. Midwives are resourceful in ensuring ongoing contact with pregnant girls and use mobile phone text to remind them about appointments and make home visits to all girls. Good information is available to young parents. A leaflet entitled ‘Being a young parent in Brighton and Hove’ is given to every girl presenting. A ‘credit card’ for young fathers provides details of a website and advice services. All girls also get the ‘Tommie’s’ book for 16 – 19 year olds. There are specific antenatal classes for young mothers which promote a normal birth. A walkabout visit to the maternity unit is well received with good uptake by young women who refuse antenatal classes.

3.14 A specialist substance misuse midwife works within the one-stop clinic. Referrals can be made by the women themselves or other professionals to this multi agency team. Women seen by the substance misuse team are assessed for capacity and a safeguarding assessment forms part of the booking process. One to one antenatal education is provided at every contact. Where a formal risk assessment identifies the need, a prenatal protection plan is drawn up with all involved agencies. Pre birth baby notes are created and kept with the mothers antenatal notes, then transferred to the babies own hospital notes at birth. There is some conflict between policy and practice around the transfer of baby notes from the mothers file to the baby’s own file and a solution that is agreeable to all needs to be found. All babies born to mothers who are known to misuse drugs or alcohol are seen postnatally by the specialist midwife. A specialist neonatologist works with the substance misuse team to manage the withdrawal programme of babies in the community.
3.15 Innovative and accessible sexual health services for young people are provided by a range of partners across the city and there is good take up of contraceptive and screening services. Sexual health services have been reviewed by young ‘mystery shoppers’ and the findings used to drive improvements with providers. Designated sexual health clinics for young people are provided weekly, although young people can access other clinics, if preferred. The central sexual health clinic provides interactive visits to schools and youth groups as part of a wider educational remit. Work is done with schools, providing PSHE resources such as the ‘Risky Business’ education package. Teenage pregnancy rates have dropped as a result of a city wide commitment; there is a good strategy and clear initiatives for prevention. Support commissioned from an independent provider for young people who seek a termination is very good and includes a joint funded counsellor, Chlamydia testing and contraception services, with clear follow up by local referring services. Child protection issues are identified early by the sexual health team and the named and designated nurses are involved. All school nurses are trained to provide contraception and advice, all staff are skill-assessed and various initiatives empower staff across services to provide consistent and accurate healthy living and self care advice to young people. The sexual health team are working effectively across the partnership, including specialist workers with very well established and effective links to specialist teams for teenage parents, YOTs, and other vulnerable children. Child protection issues are identified early by the sexual health team and the named and designated nurses are involved.

3.16 Support packages are provided to young women whose babies have been taken into care to reduce the risk of a repeat pregnancy to ‘replace’ the baby. Counselling is provided alongside aspirational work and education input. Partnership working excels with family centres providing crèche facilities whilst parents attend family learning courses with food and transport provided. ‘Choices’ a young person’s course is very well attended and aims to reduce social isolation alongside education. The teenage strategy funding provided sexual health clinics for young people on Saturday mornings and in the evenings. They have ‘Your Welcome’ accreditation. A sexual health nurse works as part of the Youth Offending service providing advice and health screening. Very difficult to reach young people are provided with bespoke and individualised care which includes long acting contraception being fitted at home. Volunteer health advisors provide ‘C Cards’, Chlamydia testing and pregnancy testing within the clinics. These volunteers are subject to appropriate recruitment, selection, training and supervision.

The Community provider service has funded specialist liaison health visitors, who work out of each of the acute trust, working closely with staff in the accident and emergency department and the children’s assessment unit. There are good links with maternity, health visiting and school nursing.

4 Outcome 6 Co-operating with others

4.1 Engagement and relationships between health service partners and with children’s services are very effective, with clear policies in place and good systems for referral, information sharing and understanding of partners’ capacity and contribution.
4.2 Staff across children’s health services are increasingly trained to recognise domestic abuse issues. Within the accident and emergency department, health visiting team, midwifery teams, CAMHS and substance misuse teams there is good awareness of safeguarding issues and domestic violence concerns are relayed effectively through the safeguarding supervision route or direct to the duty team. An independent domestic violence adviser has been appointed and all safeguarding training now incorporates domestic violence. Information on service for women subject to domestic violence is widely disseminated.

4.3 The Common Assessment Framework (CAF) is developing well with increased commitment across partner agencies having been tailored to meet local need identified by the local area partnerships.

4.4 An outstanding contribution is made to promoting the health of care leavers. A full-time nurse is assigned to the leaving care service and works with young people from age 16 onwards. Around 90% of young people take up the opportunity to have a review and appropriate priority is given to completing immunisations before they leave care. The specialist nurse is a member of the sexual health team and is able to provide appropriate support or signpost young care leavers to services.

5 Outcome 7 Safeguarding

5.1 Systems and processes for safeguarding children and young people using health services are generally very effective. Named nurses, doctors and midwives are in post and have a high profile across children’s services.

5.2 A named GP has been appointed by the PCT. There is an increasing level of attendance at safeguarding training by GPs and their practice staff with the majority of practices having received Level Three safeguarding training. However, as stated earlier in the report, GP’s have not ‘bought in’ to the idea that they have a significant contribution to make within the child protection arena. They and other professionals report communication difficulties and a lack of involvement by GP’s.

5.3 Health Trust boards all have a named safeguarding lead and receive regular reports on safeguarding and child protection, including oversight of action following Serious Case Reviews. The last serious case review was in 2008 and the action plan to ensure learning from such events has been implemented in full. This case centred on domestic violence and there is good evidence that the focus of training and the appointment of a domestic violence advocate has raised the profile of domestic violence within child protection work.

5.4 Maternity services have good risk assessments and can trigger a specialist midwife to be allocated to the family. There are clear identification and alerts from maternity staff of women and babies at risk which are followed up as part of routine postnatal care.
5.5 The accident and emergency department of BSUHT and the children’s assessment unit have a flagging system in place that identifies any child with a child protection plan on arrival at the reception desk. Triple scrutiny of all casualty cards for children under 18 years of age by a senior paediatric nurse, the named nurse and the specialist liaison health visitor negates the risk of safeguarding issues being missed.

5.6 It was confirmed that no young people with acute mental health need are placed on adult wards and there is sufficient adolescent capacity commissioned within the mental health service.

5.7 The Child Death Overview panel is working well. It has been established since 2007. The CDOP was originally chaired by the designated doctor but now by an independent chair which should improve impartiality and challenge. The panel has good representation from partners including public health, and ambulance trust which improves understanding of home environment and research evidence to assist with classification of preventable death. The panel is enabling changes to practice as a result of reviews, for example new guidance about sudden infant death syndrome, an alert to health visitors and revision of weaning guidance following two infant choking incidents and a police campaign around teenagers, alcohol and motor vehicles. As a result of another case, changes to maternity procedures, particularly around antenatal care risk identification, have been made.

5.8 All medicals are conducted in the child development centre by consultant paediatricians with specialist training in this field. Sexual abuse medicals are conducted by two consultant paediatricians including at least one of the named doctors.

6 Outcome 13 Staffing numbers

6.1 There is excellent paediatric cover for routine paediatric and safeguarding support and out of hours care. Additional safety nets have been built into the system at the acute trust to ensure child protection concerns are not missed. This includes for example, all children’s x-rays being reviewed by a consultant paediatrician.

6.2 The move of children’s emergency services from the accident and emergency department to the CASU at the RACH will result in a greater input from specialist paediatric staff at an earlier stage. Initial assessment by paediatric emergency nurse practitioners and ready access to paediatric medical staff will provide more targeted and effective care.

6.3 Many health visitors have a specific area of specialism to support colleagues and improve quality of care. Caseloads are manageable for school nursing and health visiting, although there is additional pressure on some staff during school holiday periods. Turnover is low and morale appeared excellent. Health visitors’ spoke very positively about their work. Amongst staff there is a clear ethos that child protection work is a priority.
7 Outcome 14 Staffing support

7.1 Overall across health partners training policies and programmes were very good and all staff receive safeguarding training as part of induction. A recent S11 audit by the LSCB indicated good self-awareness of training needs and content.

7.2 All clinical staff working with children or young people are expected to have undertaken level three child protection training. Staff reported encouragement for extended training – such as a sexual health nurse being funded for an MA module in expertise in safeguarding. All midwives have mandatory level three training, as do health visitors who have also had additional training in domestic violence. Although training is generally very good and staff are encouraged to attend specialist and non mandatory training pertinent to their roles, there is not specific training provided to key staff such as sexual health workers and school nurses to support them in assessing whether a young person is competent to consent in accordance with the Frazer guidelines.

7.3 Across the mental health trust staff ‘Think Family’ prompts are included in all training for adult and children’s services. CAMHS practitioners have level three safeguarding training and this is extended with access to the university modules. LSCB training is mandatory. Staff working in adult services have all had a minimum of level one training with a link practitioner having level 2.

7.4 Monthly case presentations on child protection are held at the RACH which are open to all grades of medical and nursing staff. Sessions provide teaching from experts and an opportunity for discussion. A ‘Perplexing cases’ multidisciplinary group comes together to discuss and review ‘odd’ cases that do not fit a recognised pattern. Child protection supervision for staff in acute and community providers is provided appropriately; it is valued and case file based. Health staff feel supported and are clear about how and where to seek safeguarding advice and how to make a referral.

8 Outcome 16 Audit and monitoring

8.1 There is extensive and comprehensive performance reporting on jointly commissioned services, through the section 75 agreement and also through the individual provider trusts.

8.2 There is cross agency, shared, commitment to child safety and a city wide ethos of reducing the risk of harm to young people. For example, an increase in the number of alcohol retailing outlets in areas where there is the greatest risk to young people is monitored and has resulted in a letter to the licensing authority pointing out the cumulative impact ready access to alcohol has on child protection and child safety.

8.3 Within the health visiting service, staff are empowered to be innovative and reflect on practice. Specialist sleep clinics have a very good success rate, adopting a behavioural approach with rapid results. A drop in clinic is held for traveller women and children under five at a children’s centre with group discussions and play facilities for the children. First aid courses for parents are reported to have reduced attendance at the accident and emergency department.
8.4 A child protection liaison group has been established with front line managers from health, police and social services to provide a responsive forum that can provide solutions to problems whilst avoiding bureaucracy. Review of non accidental injury conferences showed that few were attended by paediatricians. The group moving the conferences to the children’s hospital resulted in significantly improved attendance.

9 Recommendations

- Further work should be done with GPs to encourage them to be more proactive in child protection work and to recognise the wider importance of their role in safeguarding children. Within three months The PCT must ensure that robust arrangements are in place to support the full engagement of GPs in the safeguarding and child protection role. (Ofsted 2011)

- The BSUHT maternity services should review the method by which pre natal baby notes are transferred from the mothers file to the babies own file at birth to ensure babies do not get lost in the system and midwives are not required to work outside their code of professional practice within three months.

- Key staff such as sexual health workers and school nurses should receive training to support them in assessing whether a young person is competent to consent in accordance with the Frazer guidelines within six months.

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 the CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.