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

Date of Inspection	**4th April – 15 April 2011**
Date of final Report	**1st June 2011**
Commissioning PCT	**NHS Berkshire East**
CQC Inspector name	**Tina Welford**
Provider Services Included:	Berkshire East Primary Care Trust – Berkshire East Community Health Services including Slough walk-in health centre Heatherwood and Wexham Park Hospitals NHS Foundation Trust Berkshire Healthcare NHS Foundation Trust

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.

NHS Berkshire East - Slough Borough Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Inadequate
Capacity for improvement	Inadequate
The contribution of health agencies to keeping children and young people safe	Good
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being healthy	Good

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 Statutory Inspections and Mental Health Operations, 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 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:

At the time of the inspection the commissioning and planning of child health and young person's services and primary care was undertaken by NHS Berkshire East. From 1 June 2011, the commissioning and planning of children's services will be shared across Berkshire as Berkshire West and East merge to form the Berkshire Cluster (the PCTs will remain as separate statutory bodies until 2013, although managed by a single board). The lead commissioner for safeguarding (at the time of the inspection) was the Director of Public Health in Berkshire East. Some services are jointly commissioned with Slough Borough Council and others directly by the council, such as speech and language and occupational therapy. The acute hospital providing; accident and emergency, maternity and newborn services for children and young people is Heatherwood and Wexham Park Hospitals NHS Foundation Trust (HWPHNHSFT). Universal services such as health visiting, school nursing, services for children with complex needs and paediatric therapies were delivered by Berkshire East Community Health Services at the time of the inspection. Health safeguarding and looked after children (LAC) health services were also hosted by Berkshire East Community Health Services which has now merged with Berkshire West Community Health Services and Berkshire Healthcare Trust and is now known as Berkshire Healthcare Foundation NHS Trust, (this change occurred during the inspection fieldwork weeks). Berkshire Healthcare Foundation NHS Trust (BHFNHST) continues to provide child and adolescent mental health services (CAMHS) There is no youth offending institution but health provision is provided to the youth offending team via the CAMHS.

There are three general practitioner (GP) consortia in the area covered by NHS Berkshire East, one of which is coterminous with Slough Borough Council and is a pathfinder. Children and families in Slough access primary care through one of 16 GP Practices; there is a walk in health centre run by a local community interest company based at Upton Hospital (a community hospital run by the former Berkshire East Community Health Service now part of BHFT).

Slough is a predominantly urban area situated in the east of Berkshire, 25 miles to the west of Central London. At just 7 miles long by 3 miles wide, Slough is, geographically, one of the smallest unitary authorities in the UK. Slough has a total population of about 128,400 (ONS mid-2009 estimates), of which there are 30,800 children aged under 18 years (24.0% of the total population) and 33,300 aged 0-19 (26.2%) - the 19th highest amongst 152 English local authorities. Slough is a multicultural town with approximately 49% of its residents from a black or minority-ethnic background. The Pakistani and Indian communities continue to be the two largest black and ethic minority groups in the town (at 12% and 14% of total population respectively, based on 2001 Census). The 2001 census found that one-in-four Slough residents had been born outside the UK, and one-in-five born outside the EU; these rates were double those of the next highest local authority area across the south east region. Since 2001, Slough has experienced a steep growth in the number of Eastern European and Black African residents. Whilst data on the actual size of these groups is unavailable, schools census data from 2010 shows, children from an Eastern European and Black African background made up 10% and 7% of the school roll respectively, and over 50 different languages are spoken. The town has the highest proportion of Sikh residents in the country and the highest percentage of Muslim and Hindu residents in the south east region. There are also high levels of new arrivals and asylum seekers many of which are vulnerable and in need of key services.

1 General – leadership and management

1.1 There is good effective leadership through strong partnership working between health and the local authority, including a shared vision with agreed priority areas. Priorities are currently being redefined as part of the revision of the children and young persons plan (CYPP) which is well underpinned by the comprehensive joint strategic needs assessment (JSNA). Leadership at all levels is effective, however communication from the child death overview panel is not well established, especially within frontline community health services. All organisations have concurrent safeguarding policies in place, and all staff seen by inspectors were fully aware of these and the procedures they need to follow to ensure children and young people are protected and remain safe. Quality assurance arrangements are established at a strategic level across partner organisations however, these still require further embedding and maturity within some individual organisations e.g. within social care and Heatherwood and Wexham Park hospitals NHS Foundation Trust.

1.2 The views of children, young people and their parents/carers are becoming more established with respect of health service delivery, views are starting to inform health commissioning decisions and the allocation of resources. This is especially noticeable in the consultation with parents/carers of children with learning disabilities and difficulties, which has been supported by the Children Trust arrangements now replaced by the Children Partnership Board.

1.3 There is good attendance, by appropriate senior health staff, at both the local safeguarding children board (LSCB) which includes capacity to attend all four of the geographically based LSCBs and the Pan Berkshire Child Death Overview Panel (CDOP) meetings. There has been good involvement and support by the Strategic Health Authority (SHA) at the LSCB, which is enabling lessons and good practice to be identified and shared across the region. This includes a newly developed protocol (throughout the SHA area) aimed at improving the reporting and monitoring of serious incidents and revised reporting arrangements for child deaths. However, the impact of this new protocol is yet to be ascertained.

1.4 Heatherwood and Wexham Park Hospitals NHS Foundation Trust (HWPHNHSFT) has not previously been proactively involved in the CYPP planning process, however, recently this has changed.

1.5 There are a number of jointly commissioned services across Berkshire, for example, the occupational therapy for children with disabilities.

2 Outcome 1 Involving Users

2.1 There is effective service user feedback and involvement within the CAMH service, the development of contract/treatment plans, and a range of dedicated service user forums, such as those for black and minority ethnic groups and looked after children have had a positive influence on the service design. A range of leaflets have been produced, such as those relating to de-stigmatising mental health for young people. The CAMH service internet site is currently being redesigned by the service users, in response to their concerns that the website was not ‘user’ friendly or young person focussed.

2.2 There is good access to translation and interpretation services, with dedicated training for some interpreters which has supported the improvement of assessments with young people.

2.3 There is a wide range of service user feedback which is informing commissioning decisions and service development. Engagement with young people identified that they felt the sexual health services were not in suitable venues. The services have since been re-located to areas with a higher teenage conception rate, increasing the accessibility of services for the young people and targeting a known hot spot area. Further examples of effective service user engagement include; the development of the family nurse partnership, provision of the general sexual health contraceptive services, and the use of high street chemists to distribute free condoms. The sexual health services, along with four other services, are currently working with groups of service users to gain the 'You're Welcome' accreditation. Young people are able to effectively raise concerns to the health sexual health worker, when this has happened, these has been resolved successfully. The children with disabilities and complex needs health promotion service (along with 3 other services) are just commencing accreditation with service users through the 'You're Welcome' standards.

2.4 Due to the identification of concealed pregnancies (up to 20 weeks gestation) dedicated work with young women, identified that this was due to the fact that they did not want to have/or were 'scared' to have an abortion, In order to dispel myths, additional training in schools has been implemented which has increased awareness and the number of young people approaching sexual health services earlier for abortion advice, or support. Feedback from young women to improved accessibility to the contracted termination of pregnancy service, this was recommissioned and the service has been brought back into Slough borough, previously in one of the London boroughs.

2.5 Parents of children with complex needs highly value the engagement of health partners and the local authority. They describe the engagement as good to excellent with active listening to concerns and prompt action being taken to resolve issues.

2.6 Staff working in the substance misuse services have good knowledge of the cultural issues within the local community, relating to substance misuse. Strategies are being implemented to minimise risk and educate parents, through working with faith and community leaders. However, it is too early to measure the impact of this work.

3 Outcome 2 Consent

3.1 Health provider organisations appropriately apply a range of competence tests to ensure that lawful consent is gained from children and young people. There is good application of the Fraser guidelines prior to treatments in sexual health services ensuring young people are competent to consent and fully aware of their options. General practitioners contact social care in relation to looked after children to social care, when they have concerns relating to parental consent, to ensure children and young people are protected from harm. If the child is under five years old, the concerns will also be shared with the family health visitor. All looked after children health assessments are undertaken once social care has secured a valid consent.

4 Outcome 4 Care and welfare of people who use services

4.1 There is a sustained reduction in both teenage conception and pregnancy rates, which are lower than England average and statistical neighbours. Through good levels of sustained engagement with the young people and the family nurse partnership scheme, young people's aspirations are improving, which has been partially attributed to the 'drop in' service flexibility and the schemes of work individually undertaken with the young women. The findings from the longitudinal randomised controlled trials research (part of the FNP evaluation) is yet to be concluded; early results are starting to show that there is a reduction in the rate of second conceptions and successful implementation of the 'delay 'messages. However, the rate of young mothers in or returning to education and employment remains low. There has been a range of targeted and well attended sessions for young fathers and fathers- to- be commissioned by the Sure Start Children Centres and provided by the health visiting service. These sessions are highly valued with high attendance rates being maintained, due to the fact the sessions are held in evening and on Saturdays. However, funding streams ceased at the end of March 2011 and health visitors are unclear as to what arrangements are now in place. School nurses deliver an adequate range of personal health and sexual education (PHSE) and sexual relationship education (SRE) programmes. School nurses do not provide dedicated sexual health clinic services within schools. However, they do provide well accessed 'drop in' clinics, supporting and accompanying a young person to attend the local sexual health clinic, The Garden Clinic.

4.2 There is a wide range of referral sources for child and adolescence mental health services (CAMHS), however, there remains a high rate, albeit reducing, of inappropriate referrals to tier 3 services, the majority coming from primary health care services. As a result, additional training has been planned for primary care staff as part of the three monthly educational days (STEPS). All emergency referrals are seen within 24 hours. There is good access to tier 4 beds, both day and inpatient beds. There remain inaccuracies within the looked after and child protection referrals reporting data, resulting in an inaccurate picture of activity and quality of service provision, due to problems with the information performance systems which were being addressed at the time of the inspection. Referral to conversion rates and commencing treatment is good, the majority commencing within four weeks of referral. All looked after children (LAC) referrals are seen within two weeks.

4.3 Dental health within the general population is poor with 46.2% of children at 5 years old having at least one tooth filled, decayed or missing and a similar picture for older children at age 12 years, this is significantly above the England average. However, there is good access and 'take-up' of dental assessments for looked after children in 2009/10 the rate was 94.7% which is above England and statistical neighbours.

4.4 Health assessments for looked after children and young people are above England and statistical neighbours at 94.7% (2009/2010). The cumulative rate dropped in February 2011, to 80.8%. This drop in the assessment rate correlates to the increasing number of children and young people who become looked after. Projection planning estimates that the end of year rate will match last year's data. Immunisation and vaccine rates are good. A good and flexible appointment system operates for the weekly health assessment clinics, which is ensuring there is good opportunity for health assessments and reviews to be undertaken at a time suitable for the young person. Due to the increase in looked after children (LAC), which has adversely affected the capacity of the medical team to undertake the initial health assessments, the named GP and community paediatrician now support the medical team, ensuring that all initial health assessments are undertaken in line with national guidance. Health assessment/review action plan implementation is not effectively monitored by social care and IROs; of the four cases reviewed by inspectors two had incomplete actions by social care staff, which has remained incomplete for more than 12 months.

4.5 Care leavers currently do not have a copy of their health history. The care leaving process has recently been reviewed and changes are being implemented. However, it is too early to measure the impact. There is good signposting to universal health services for looked after children and care leavers, the latter of which are all registered with GPs and dentists. Community health staff have good access to and attend LAC reviews meetings, which have helped to improve liaison with the health LAC team.

4.6 Whilst there is an improvement in the monitoring of the health assessments, for the LAC placed out of area, there remains poor communication and notification of the changes in placement circumstances (for all LAC) from children's social care to the looked after children health team. Notification process of new looked after children and young people to health staff from social care, had been working well, until about 3 months ago and is now inadequate. LAC health staff do not directly receive notifications from unscheduled care settings of LAC attendance; they occasionally receive notifications of hospital admissions. This lack of communication is inhibiting effective assessment and monitoring of health needs.

4.7 Across the SHA area, work has commenced on securing a funding strategy for undertaking out of area looked after children health assessments, however, this is yet to be realised.

4.8 There is good access to translation and interpretation services (including the use of sign language for those hard of hearing and deaf) with dedicated support and training for interpreters, including most recently for those working with people from Afghanistan and unaccompanied asylum seekers. Some of the interpreters have received dedicated training to help them support assessments such as in the case of sexual health assessments and sexual health relationship education. There have been a number of staff appointments with a dedicated focus on working with some of the local BME groups, community and faith leaders. For example, dedicated staff to work with Somalian women to identify and effectively address their health needs, and dedicated midwives and health visitors for Roma families.

4.9 There is good partnership working between health, the police, youth offending services and children social care staff, using a holistic approach to families where adults are substance misusers and/or where there have been instances of domestic violence, in order to protect the child. There are good psychosocial counselling services within the substance misuse services, working with young people up to the age of 25 years on a one to one basis, using harm minimisation techniques to change risk taking behaviours. The 'youth bus' and the 'drug box' are effectively used in engaging young people with substance misuse services, who may not otherwise engage or highlighting risks, by delivering a flexible and approachable service in venues used by young people. This, along with effective relationship building between staff and young people, is ensuring that the young people attend services and stay engaged with all services for the duration of their treatments and during transitions points.

5 Outcome 6 Co-operating with others

5.1 CAMHS and the Emotional Health and Well-being Service (EHWBS) have received national acclaim for their work. There is a dedicated looked after children (LAC) service providing good support to LAC and their foster carers. A triaging single referral 'hub' has been effectively established. Rates of GP referrals to tier 2 CAMHS remain low, although improving. 'Did Not Attend' (DNA) rates remain high, at 14% (although below trust target). Initiatives were introduced in September 2010, such as reminder calls and texts, choice appointments and the partnership approach (CAPA) system that are starting to impact. Good and effective use of failed to engage policies and procedures are increasing young people attendance and ensuring they are protected from harm. There is good partnership working between tier 2 and tier 3 CAMHS, with referrals being reviewed on a daily basis and at weekly 'hub' meetings supported by good multi agency assessment, all of which has improved communications and sharing of intelligence related to the families. Looked after children (LAC) referral rates from social care to tier 1 and tier 2 EHWBS and CAMHS have increased throughout the year. However, it is not always disclosed at the point of referral that the young person is LAC or subject to child protection arrangements, so their cases cannot be prioritised. Partnership working with the local authority has been identified as an area to improve, but it is too early to measure impact of the changes. Transitions to adult mental health/learning disability services are good, with effective tracking of all 16-18 year olds and good joint working arrangements are in place. A flexible approach is taken to all new referrals over the age of 17 years, with effective joint and co-working with adult mental health services based on the individuals needs.

5.2 The outcomes of the strengths and difficulties questionnaires (SDQ) are not used in the looked after children health assessments and are not shared with the LAC health team, CAMHS staff or children social care as part of the referral to CAMHS. LAC health staff can refer directly to tier 3 CAMHS, however staff reported that they have no direct referral to tier1 or tier 2, referrals have to be made by social workers. As a result health staff do not receive feedback on the status of the referral or are not aware if the health action plan has been implemented. This was addressed during the inspection. Health staff gave examples of cases where, despite the request being documented in the health action plan, the referrals had not been made within 12 months the initial request. This had not been addressed by the IROs during their monitoring and review of assessments and associated action plans.

5.3 There is good use of parallel processes with Connexions, education and other care providers providing treatments, which are effectively supporting the family (including foster carers) meeting needs and providing a holistic approach to mental health, substance misuse and sexual health services. There is good support and education provided to the residential children home with dedicated and targeted health promotion activities.

5.4 Most health staff were aware of thresholds to make safeguarding referrals to children's social care, however, there have been a number of recent changes and some staff were unclear what the current thresholds were. They reported that the referral feedback form (which is on the back of the referral form to social care) has never been returned to them, and frequently they spend considerable amounts of time trying to find out if the referral has been accepted and what action has been taken. The hospital based social workers at Wexham Park Hospitals, have addressed this and they follow up all referrals, ensuring health staff receive feedback. Slough walk-in health centre staff had not received feedback from children's social care on referrals that they had made. Family Nurse Partnership (FNP) workers, have a link social worker which has improved communications, helped to clarify thresholds, and has provided feedback on referrals. There is good attendance by health staff at children protection meetings. Case conference and child protection reports are submitted within timescales. Whilst there have been no recent serious case reviews (SCR) in Slough, a number of staff are involved with other SCR in the Berkshire East area, and lessons learnt are increasingly shared across the Slough area.

5.5 There is a good range of highly valued and well attended training sessions for foster carers, both new and established, as well as prospective foster carers, potential adopters and new adoptive parents, ensuring that they have the required skills and knowledge, to maintain placement stability.

5.6 Speech and language therapy services generally do not use formal referral processes. Access to services is through the weekly 'drop in' sessions at Sure Start Children Centres, although these are over subscribed. Due to the sessions being oversubscribed parents are turned away and told to attend the next drop in clinic. However, there is no robust monitoring as to whether these parents return for assessment or treatment at a future date. The data shows that there has been an improvement in the number of children experiencing developmental speech delays. This same approach applies to looked after children however; if the child is known to be 'looked after' they will gain priority at the drop in session.

5.7 Occupational therapists and physiotherapists working with children with complex needs have changed from universal to early identification and targeting provision. As a result, there is good pathway design for therapy services resulting in joint assessments and goal setting. This is most noticeable, as collaboration with parents and children and young people with learning disabilities and difficulties have successfully reduced the number of visits required to services and provide a more comprehensive 'team around the child' style service. This approach has also helped coordinate services in line with the common assessment framework (CAF) when these have been used.

5.8 A wide range of training is provided for all staff both for safeguarding and skills based training. This includes dedicated skills based training provided by therapists for staff working within education settings which, as a result, has increased the levels of support given to children and young people within classroom settings. Further, this has improved the range of educational opportunities for young people with disabilities including enabling them to attend mainstream schools. Community children nurses have effective and close working arrangements with both children and adult social care staff. This integrated approach, with a supporting transitions pathway, is ensuring that transitions are safe and successful for all young persons, including those with complex needs. This is supported by effective family care plans (supported by e-CAF if in place) that are monitored through regular meetings with families and their advocates. A range of good dedicated projects for children with disabilities is promoting 'good health'. For example, dental hygiene (with onward referral and support from the community dental services), dedicated sex and relationships programmes (notably for children with learning difficulties and disabilities and complex needs) as well as dedicated programmes for safeguarding related to personal boundaries.

5.9 Case conferences and the range of other safeguarding meetings are well attended by health staff who are able to effectively challenge decisions. However, attendance by adult mental health services is less consistent. When issues need to be escalated health staff have good access to the chairs of meetings, in order to raise their concerns directly and gain satisfactory resolution.

5.10 Early intervention and the work of the integrated youth support services with partner agencies are improving the engagement of young people, especially with substance misuse services. The youth offending teams (YOT) are working effectively with the local colleges and health improvement teams to provide a good co-ordinated approach to the provision of harm reduction information and when required, access to services. There has been dedicated and targeted educational provision for parents within the general population, relating to substance misuse and mental health, as part of the strategy to change the cultural acceptance of substance misuse in the local population. However, it is too early to measure the impact. There are good links between YOT, emotional health and wellbeing teams and mental health teams, resulting in joint working and the promotion of better trusting relationships with young people. The Drug Use Screening Tool (DUST) tool is effectively used, including within LAC health assessments, by the dedicated parental workers based in the YOT. The results are used to support the young person, their social worker and /or carer during the treatment interventions. The named YOT worker for a LAC young person will attend the LAC review meetings, ensuring that there is a consistent approach to treatments and to maintain placement stability.

6 Outcome 7 Safeguarding

6.1 The designated looked after children medical staff undertake all adoption medicals and are good involved with the adoption and placement panels. They also undertake all initial medicals on children and young people as they come into the care system, and ensure that suitable health plans are in place to protect the child. Looked after children health staff are well engaged in and support training for foster carers, potential and new adoptive parents. They provide good support, health related training and advice to the staff within the local children homes, along with the dedicated youth worker who supports the staff in the local hostels, especially when there has been substance misuse identified, which is ensuring that coping and harm reduction strategies are implemented.

6.2 The highly valued named nurses and midwives for safeguarding have good integrated partnership working arrangements across all the local health organisations and those organisations across the authority boundaries. Good links with childrens social care are starting to be established (all named staff have only been in post for less than a year, with most in post for just 6 months), which is improving communication and sharing of information. The designated nurse for safeguarding post remains vacant after unsuccessful recruitment; the role is currently being effectively covered by other staff from the public health team. The named general practitioner post is established and acts as a useful resource for practices. There is a lead GP for CAMHS who has only been in place for four weeks, the role is to improve the interface and relationships between CAMHS and primary care. The new dedicated mental health service based safeguarding leads, (which are above the named nurse and doctor establishment) are effectively working with the health named practitioner safeguarding teams. These two countywide posts are currently reviewing mental health services, including the support given by adult mental health services to families and children and young people through the hidden harm strategies. Furthermore, there have been changes to the training programmes to make them more relevant to this staff group, with the aim of improving compliance to the hidden harm strategy, developing better identification of needs through improved assessment of families and by increasing further the multi agency working. Job descriptions and reporting structures for all named and designated safeguarding and looked after children health named and designated posts comply with statutory guidance.

6.3 Most health staff are fully aware of referral thresholds and raise referrals and 'cause of concern' notifications, as required to children social care and the emergency duty teams outside of normal working hours. The latter forms are also sent to the named practitioners for information and peer review. The named practitioners follow up referrals and peer review outcomes at their meetings with staff and social care, and if a cause for concern form is completed with no referral to social care, this would be discussed with the practitioner and support and supervision given to make a referral to ensure children and young people are effectively protected from harm. Any trends and learning points are incorporated into mandatory training.

6.4 There are effective psychosocial risk meetings held at Wexham Park Hospital site, (part of HWPHNHSFT), with the hospital social workers (HSW), leading to rapid and robust solutions and responses to queries and safeguarding referrals. Thresholds are becoming better understood and the HSW have been instrumental in understanding the differences between the individual organisations classification of risks and risk assessments facilitating referrals. Recently communication has improved between community health staff and children social care staff. Neonatal services have good links and regular meetings with hospital social workers, the named nurse and named midwife ensure that there are good and effective pre-planning birth meetings, when risks have been identified, to protect the unborn child.

6.5 The Family Nurse Partnership (FNP) practitioners work effectively with young women and their youngest babies (up to 2 years old) including those who are looked after and/or care leavers. They are providing a good level of support and regular monitoring of their additional vulnerabilities. The ethos of an approachable and flexible service has ensured that families remain engaged with the programme. Anecdotal evidence for the current year and the data from previous years, suggests this is successful in raising aspirations not only with the women and their partners, but also with their peers. Good links between the FNP and the hospital social workers is promoting the effective use of information sharing and timely action to protect and minimise vulnerabilities. The FNP deliver part of the healthy child programme and support contraceptive clinics, for those who attend the sure start children centres, due to their established working and trusted relationship with mothers who would normally not engage with statutory services. The impact of this is too early to measure.

6.6 Through the good integrated and targeted sexual health work, (which is linked to the teenage pregnancy strategy and also sexual exploitation strategy), and with the integrated youth support teams. There is timely and easy access for young people to the full range of sexual health services, supporting young people and giving them strategies to reduce their vulnerabilities and protecting them form harm. Services are highly valued and well accessed by young people, although formal data collection is yet to be completed. Through good access to and a well attended condom supply service throughout the borough, at locations identified by the young people as accessible to them, which include high street chemists. Anecdotal evidence suggests that this is contributing to less unwanted and second pregnancies.

6.7 There is good targeted provision in Westgate School of a dedicated work programme aimed at groups of young people at risk of becoming pregnant, addressing sexual health and risk taking behaviours. Outcomes, to date, show that none of the identified young people who have completed the dedicated programme have become pregnant and there has been a reduction

6.8 Health staff along with partner agencies are well engaged with known cases of domestic violence across the authority supported through good multi agency referral and assessment centre (MARAC) arrangements with effective interagency working and action planning to ensure that children and young people remain safe. Less effective engagement arrangements are in place with the multi agency public protection arrangements (MAPPA). All health staff have access to good quality domestic violence training, which focuses on both genders. All incidents of domestic violence, where there are children under the age of 5 years, are followed up by health visitors, ensuring that the child remains safe.

6.9 Dedicated maternity and health visiting staff carry out joint visits to young people who are homeless. These visits have proved effective in increasing access to universal health provision and are improving health outcomes for this vulnerable group of young people.

6.10 The Crystal team provides good support for vulnerable pregnant women and their unborn and new born babies, developing positive relationships through one to one support within a flexible delivery model. There is good close working and joint visits with the hospital social workers. Community midwives continue to follow up and support vulnerable families post birth for 28 days along with the health visitor in order to minimise the vulnerabilities and risks that have been identified.

6.11 Focus groups of Somalian young people, those from Asia and Afghanistan and unaccompanied asylum seekers, have been developed that address issues relating to their cultures with respect to both sexual health practices e.g. sexual exploitation, genital mutilation, sexually transmitted diseases and substance misuse including other risk taking behaviours. These have resulted in an increase in the use of preventative services. There is a good range of well accessed dedicated support for lesbian, gay and bisexual young people, which is meeting needs at the individual level through direct work. Sure Start Children Centres provide a range of young parent and toddler support groups in response to needs identified by young people and especially those wishing to return to education. There are dedicated outreach workers for Roma families using a good range of interventional techniques. The dedicated maternity and health visiting staff work with the homeless and Roma families through effective joint visits to improve the health outcomes of the young people, who would not normally attend statutory services. These schemes are contributing effectively to the raising of aspirations of young people and improving their parenting skills.

6.12 All A&E staff have access to paediatric life support, paediatric trauma courses and qualifications at appropriate levels, with all children A&E nursing staff being up to date with this training. Medical staff all hold basic life support training and middle grade doctors have paediatric life support skills certificates. There are no children qualified nurses on duty overnight, there is a dedicated children A&E for twelve hours a day through the year. Ambulance staff notify A&E staff of any child that may require resuscitation or place a ‘trauma call’ which effectively ensures that the appropriate staff with the correct skills are available to care for the child or young person on their arrival at A&E irrespective of the time of day. Self harm treatment complies with the NICE guidance, with good access to liaison psychiatry and crisis intervention teams. There is good joint working with police and ambulance services when a Section136 (of the Mental Health Act) is required and the young person requires health treatment, which is ensuring that the young person is appropriately cared for and protected from harm. There is a good handover from ambulance staff to A&E on notification of any risk and/or safeguarding concerns noted when they collected the child or young person or an adult when there were children within the home. Ambulance crews submit safeguarding referrals to children’s social care directly, copies of the forms are 'handed over' to A&E staff for their records and to support any further cause for concern notification, thus ensuring a coordinated and complete approach to monitoring and protecting the young person form harm. This also includes any adult referrals and hidden harm referrals.

6.13 A&E and unscheduled care attendance notifications are sent via the named nurses, to community practitioners 'for information only'. In some cases, there is liaison with GPs, however, not all health visitors or school nurses attend practice meetings to discuss the notification and families of concern, which may result in actions not being followed up effectively and a lack of assurance that children are safe and protected; this was being addressed during the time of the inspection. The Slough walk-in health centre data system does not easily identify frequent attendees, which can result in the information not being readily available for the staff in the Slough walk-in health centre or primary care staff. The information system in the Slough walk-in health centre and in Wexham Park Hospital does not electronically identify those known to be looked after children, or subject to child protection procedures or identify the local childrens home addresses. As a consequence A&E staff and Slough walk-in health centre staff contact children's social care or the emergency duty teams when they have concerns relating to safeguarding to see if the child or young person is known to social care, however this has not caused a concern for staff, who report that children are effectively safeguarded. The consenting process for looked after children is not robust, as there are insufficient safeguards to ensure that appropriate consent is obtained, although staff where unable to identify any incidence were this had occurred.

6.14 There are dedicated nurses, working as part of the local rapid response team for the pan Berkshire CDOP, who provide effective support to families during the immediate bereavement period supporting any police investigations. There has been within the last seven months, an increase in the number of sudden infant deaths, across Berkshire (not in Slough specifically). As a result, additional training is being implemented for community practitioners. Community practitioners and those staff working in the Slough walk-in health centre were, however, unaware of any communication relating to the increase in sudden infant deaths and actions that they should be taking with families. As a result of an increasing number of cot deaths, perinatal leads and links with mental health have been established and health visitors have become further involved with implementing safe sleeping messages, in order to increase the level of education to new parents. The impact of this has yet to be identified.

6.15 Annual child death reports are presented to the LSCB and are effectively monitored and reviewed. CDOP hold reflection days, where a number of deaths across Berkshire are reviewed and the lessons identified and disseminated. There is good engagement and effective information sharing with the local coroner's officers and CDOP to monitor trends. CDOP has effective links with voluntary sector bereavement support for families and the siblings affected by a child's death. There is lay representation on CDOP.

7 Outcome 11 Safety, availability and suitability of equipment

7.1 The sexual assault and referral centre (SARC) opened on 1 April 2011. This is the first centre in the Thames Valley area and is located at Upton Hospital in Slough. Prior to this traumatised young people and children were being transported out of the borough. Pathways for access still needs to be disseminated. A&E staff were not aware, until they read in their local paper, that the new SARC had opened. Procedures for referral etc are not known by unscheduled care and ambulance staff. This was being addressed during the inspection.

7.2 Wexham Park Hospital has a dedicated 12 hour children accident and emergency department, outside of these times children and young people have to use the adult facilities, which do not have dedicated children's waiting area, although has a dedicated resuscitation bay within the adult resuscitation facility.

7.3 Parents of children and young people with disabilities have good access to medical/health loan equipment. However, some parents report that there is, at times, a lack of signposting to non-statutory services when they do not met the requirement for continuing health care funding, who can be accessed to provide or fund equipment. This results in them often struggling to cope and in some cases reported, prevents them from going out as a family. There is some recycling of equipment, ensuring that resources are effectively used.

8 Outcome 12 Staffing recruitment

8.1 All the health organisation safeguarding audits and Section 11 audits show that there is good compliance with criminal records bureau (CRB) checking; however, practice nurses and some practice staff are reported yet to have an enhanced check, this is currently being addressed.

9 Outcome 13 Staffing numbers

9.1 Workforce and skills mix review are continually undertaken to ensure that there are the right staff in place; however, there still remains a shortage of health visitors, which is increasing the workload of those in post. However, long term plans are being introduced following the skill mix review, which included school nursing services, to try and address the vacancies and give stability to the workforce. A number of posts have been offered to commence in June 2011, pending successful completion of training, and completion of recruitment procedures. There are no childrens qualified nurses employed within the Slough walk-in health centre, despite an increasing number of children and young people attending the service. There is only a draft joint workforce strategy with social care in place; further development is needed to ensure that there is workforce fit for purpose.

10 Outcome 14 Staffing support

10.1 The SHA lead for children and young people meets on a regular basis with all the designated and named health professionals for safeguarding and looked after children. Through these meetings practices are reviewed, benchmarked, and good practice shared. These meetings also evaluate the impact of the leadership programme, which has been running for 3 years. However, there is no robust evaluation of the impact of any other safeguarding training within health organisations and assurance that changes to practice have been implemented. The lack of evaluation has recently been identified by the LSCB and is included in the forthcoming business plan which is currently being developed. All staff interviewed reported to be up to date with their safeguarding training. There are effective networks across the county and SHA area, offering a range of training opportunities and support for policy development.

10.2 The looked after children team, have good access to supervision, however the staff (some of which are social care staff) who work within the team, supporting emotional health and well being, have not received supervision for the last 5 months despite escalating their concerns to senior managers. CAMHS staff have good access to highly supportive supervision and peer reviews. All CAMHS staff are up to date with the appropriate level of safeguarding training. The FNP now have access to supervision with CAMHS staff which has enabled an earlier recognition of needs and therefore tier 1 interventions can be implemented or prompt referrals are made to tier 2 CAMHS. There are highly valued and well accessed domestic violence, fabricated illnesses, forced marriages, genital mutilation and child trafficking training programmes.

10.3 All named safeguarding staff receive regular supervision helping them undertake their roles, with regular management support from executive leads. Staff at Slough walk- in health centre report that they do not have contact with, or support from, the designated or named safeguarding health staff. All staff, though, are up to date with their safeguarding training, which is delivered by the named doctor and named nurse.

10.4 Access to multi agency level 3 safeguarding training (as currently defined, the current training matrix which was being revised in line with national guidance at the time of the inspection) remains a challenge, mainly due to the lack of capacity of courses and the securing of funding for places. However, single agency level 3 training show high rates of completion. The local ambulance service staffs, seen as part of the inspection, have good internal training but have not been able to access domestic violence training with other partners. Despite this, working relationships are strong especially with A&E staff and local police. Externally contracted portering staff interviewed at HWPHNHSFT, have not received safeguarding training, however, the A&E portering staff seen as part of the inspection, were aware of how to escalate concerns, (and had done so) and where they can gain support. All A&E staff including the local based ambulance personnel, junior doctors ‘on rotation’ are up to date with training at the appropriate level, which is mandatory on commencing within the service. General practitioners are making effective use of protected learning time (STEP) to maintain high levels of compliance with safeguarding training requirements, in line with other staff groups.

10.5 The sexual health teams, including the sexual health promotion specialist post and the staff from the targeted and integrated youth support services, provide a range of sexual and relationship education to staff in the residential children homes. Further they will work with both individual looked after young people and their parents/foster carers in promoting safe sexual health. There is good training in place for youth workers enabling them to effectively support young people and build trusted relationship to discuss sexual vulnerabilities due to the young person's risky behaviours.

11 Outcome 16 Audit and monitoring

11.1 There is good monitoring of information and electronically circulated newsletters from CDOP of new initiatives and national learning from CDOP cases, although frontline community staff report that they do not always receive these communications. There is good ongoing audit and performance monitoring of action plans by the strategic health authority (SHA), LSCB and the health scrutiny panel, which includes the review of all Section 11 audits. The latest Section 11 audits show a good level of compliance. The health scrutiny panel provides effective challenge and monitoring of health safeguarding action plans. Safeguarding steering groups within health providers are at variable levels of maturing and effectiveness.

11.2 Following a baseline safeguarding audit within adult mental health services, a safeguarding assessment tool was introduced, resulting in an increase in the number of children and young people referrals made to social care, especially those relating to young carers and those subject to hidden harm, however, it is too early to determine any sustained impact on improving outcomes.

11.3 Sexual health services have a good awareness of the local population and their individual cultures with good use of data, resulting in targeting of interventions and services to meet specific needs However, in the 'hot spot' teenage conception areas this is yet to make an impact.

11.4 There is effective multi agency sharing of intelligence relating to substance misuse especially between the youth offending teams, police and the integrated youth support teams. This, along with the MAPPA, is ensuring that those at higher risk of vulnerabilities or families with complex needs are referred to appropriate services in a timely manner.

11.5 As part of the strategy to improve child health including the reduction in childhood obesity and the health of the local population, there is good initiation and 6 week breast feeding rates, which in 2009/10 were above the England rates, the long term impact of this is yet to be measured.

12 Outcome 20 Notification of other incidents

12.1 The current processes for notification of serious incidents across the SHA area are under review, as there is over reporting and the roles of designated health professionals across the SHA area has now been clarified.

13 Outcome 21 Records

13.1 All health files seen during the inspection complied with professional guidance and contained chronologies, with some evidence of follow-up from the actions plans. There was no evidence of supervision within these files; however staff reported good access to supportive supervision.

Recommendations

(those recommendations in italics from the Joint report with OFSTED)

Within 3 months

Slough Borough Council and NHS Berkshire East must ensure that care leavers receive copies of their health histories to equip them to make effective future health choices

Slough Borough Council and NHS Berkshire East ensure that the system for social care notifying health of the changing circumstances of looked after children is effective and timely.

NHS Berkshire East should ensure that there are effective communication channels for the dissemination of information, including service delivery changes and referral pathways in order that staff can ensure that changes in practice to safeguarding children and young people can be implemented.

NHS Berkshire East ensure that adult mental health services are effectively engaged in work with children services in families where parents or carers have mental health problems

NHS Berkshire East must ensure that consenting processes for looked after children and young people accessing health services and unscheduled care settings complies with national guidance and good practice.

Within 6 months

NHS Berkshire East and Slough's LSCB should ensure that there is effective monitoring of the outcomes and impact of safeguarding training within health care organisations.

NHS Berkshire East must ensure that within the Slough health walk-in centre that there are appropriate qualified nursing staff on duty to meet the needs of children and young people using the service.

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.