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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<th>Safeguarding Inspection Outcome</th>
<th>Aggregated inspection finding</th>
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<td>Overall effectiveness of the safeguarding services</td>
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<tr>
<td>Capacity for improvement</td>
<td>Good</td>
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<tr>
<th>Looked After Children Inspection Outcome</th>
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<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
<td>Good</td>
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<td>Capacity for improvement of the council and its partners</td>
<td>Good</td>
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This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

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

The Inspection Process

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

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

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

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

Portsmouth is a waterfront city and port on the south coast of England with a population of 196,400 living within 15.5 square miles. 79% of the population live on Portsea Island. It is the most densely populated area in the United Kingdom outside London with 7.8% of households living in overcrowded homes. Average house prices are comparatively low. It is renowned for its maritime heritage and for being the home of the Royal Navy for over 500 years. The population is mainly white British - estimated at 88% in 2005. This is higher than the regional and national averages. The largest minority ethnic groups are Chinese, Indian and Bangladeshi. Over 70 languages are spoken in the city. Children from black and minority ethnic groups comprise 13.5% of young people of school age. There are over 46,000 children and young people up to the age of 19 living in Portsmouth, representing 23% of the city’s population. This number has changed little over the past five years and is not expected to change significantly over the next five. Most are permanently housed and not living in overcrowded accommodation. However, 16% of children and young people live in workless households and 18% in poverty. There is significant deprivation in the city. The Index of Multiple Deprivation 2007 identifies Portsmouth as the 93rd most deprived of 354 councils in England.

The Portsmouth Children and Young People’s Local Strategic Partnership was set up in 1999 and the Children’s Trust established in 2005. The Trust includes representatives of NHS Portsmouth, Portsmouth Hospitals NHS Trust, Solent NHS Trust and general practitioners, Hampshire Constabulary, the Voluntary Sector Alliance, young people representatives, schools and the further education sector. The Portsmouth Safeguarding Children Board (PSCB) is chaired by an independent chair and brings together the main organisations working with children, young people and families in Portsmouth.

Commissioning and planning of health services are carried out by NHS Portsmouth. Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by Solent NHS Trust. The acute hospital, Portsmouth Hospitals NHS Trust, provides accident and emergency services for children and maternity and newborn services. Urgent care for children can also be accessed through St Mary’s Hospital Minor Injuries Centre. Learning disability services are provided by Portsmouth City Council and Solent NHS Trust. Child and Adolescent Mental Health Services (CAMHS) are provided by Solent NHS Trust. There is no age-appropriate mental health in-patient accommodation for children or young people who require specialist care. In the very few instances where this occurs provision is commissioned from healthcare providers outside the city.
The health of children in Portsmouth is generally worse than, or in some cases similar to, the England average. Infant and child mortality rates are similar to average, and breastfeeding initiation levels are similar to average. Children in Portsmouth have higher than average levels of obesity: 12.3% of children in reception and 22% of children in year 6 are classified as obese. 53% of children participate in more than 3 hours of sport a week, which is higher than the England average. Hospital admission rates for alcohol specific conditions and for substance misuse are similar to the England average, but the admission rate for injury is worse than average. The percentage of children who say they use drugs is similar to average and the percentage of children who say they have been drunk recently is higher than the England average.

General – leadership and management

1. The contribution of health services to keeping children and young people safe in Portsmouth is good. The director of public health provides effective leadership for children’s health services and there is clear ambition and prioritisation regarding the importance of safeguarding and the promotion of children’s’ health and wellbeing in a multi-agency and multi-disciplinary approach.

2. Senior managers are key members of the Portsmouth Partnership and the Children’s Trust which set shared priorities and drive service delivery and development and health have played an important role in developing the new Children’s Trust Plan. There is a clear understanding across the partnership of the national context for the delivery of children’s services and of the local challenges within that context. Health’s early intervention provision and other partnership work is effective and is resulting in positive outcomes for many children, with good early identification of their needs for safeguarding and protection.

3. The relatively new PCT children’s safeguarding board which reports to the multi-agency safeguarding children’s board, is developing well but has yet to become fully effective as a commissioning body driving improvements in provider health services. While there are safeguarding children’s boards in health provider services which report to this board, there is no clear overall work programme to steer improvements, measure year-on-year progress and identify specific areas for development in individual providers.

4. Building on achievements to date and ensuring on-going effective governance of safeguarding performance is for the new GP Commissioning Consortium (GPCC) to address at an early stage. The production of the PCT safeguarding board’s annual report this summer gives a good opportunity to begin to establish a performance management framework and work programme for safeguarding, setting measurable outcome focused objectives in acute and community services. This could also lay a useful legacy foundation to inform the work of the GPCC.
Outcome 1 Involving Users

5 Aspects of health services for children are well informed and influenced by children particularly over the past year where the youth forum, Check It Out, has evaluated and accredited services against the You’re Welcome criteria. An enthusiastic and articulate group aimed at young people aged 12-21 and keen to help deliver improvements to local health services; the group recently won the South East region empowerment award for both adult and young people’s groups.

6 Where services did not achieve accreditation initially, services have been improved in order for accreditation on reassessment. In one service, offering sexual health advice and support, a clear window was replaced with frosted glass as a result of Check IT Out’s evaluation, thus affording increased privacy for young people accessing the service. Health services are now approaching the group requesting assessment as they recognise the growing local significance of receiving Check It Out’s seal of approval.

7 The group has also designed a new step-by-step guide for children to services at Queen Alexandra (QA) hospital, taking their own photographs so that children would find it easier to relate the information to their own hospital experience. Check it Out has also advised the sexual health services on communicating with young people and offers training to GPs on what makes good health services for young people. This group has clear potential to be engaged in other aspects of developing and quality assuring children’s health services.

“No one knows what good health services for young people look like other than young people” – chair of Check IT Out (aged 15)

8 Service user engagement can be developed further however, particularly for children who are looked after. Regular health focused events are held to engage young people and foster carers and health packs are being trialled with a group of young people who contribute to service development, some of whom are looked after. Young people have not been involved in health staff recruitment nor the recent recruitment of the new looked after children’s (LAC) nurse, although this is routine practice in social care, and the Children In Care Council has not considered health issues in its work to date.
Interpreting and translation services are accessible, sensitive to gender issues and try to meet specific requests. When a child or family needs medium or long-term communication support, the service aims to ensure continuity of interpreter. Health is committed to the use of independent interpreting from outside the family whenever possible. Information on health services is available in a range of languages and formats including some DVD presentations. Parents of children with disabilities were uncertain of the location of health visitors and how to access the service as they understood arrangements had changed recently.

Parents and children influenced the design of the CAU where they are also encouraged to complete satisfaction surveys. Hospital managers draw out themes from these along with issues raised in feedback letters from parents but there are no interactive facilities which could encourage engagement with younger children. A bid for “Fergie the Frog” interactive system had been unsuccessful. Staff are mindful of the You’re Welcome criteria and are aiming to develop services in line with these.

Outcome 2 Consent

Appropriate policies and procedures, in line with national guidance, support staff to ensure consent is obtained prior to children and young people having treatment. Staff are aware of the need to establish who can give consent and will check with social care if they are in doubt. When the multi-disciplinary team is working with children with complex conditions which may often require urgent intervention, clear knowledge and clarity around the consent issues is established at an early stage so that treatment will not be delayed.

Consent to undertake health assessments for looked after children is sought in line with Department of Health guidance and where surgery is proposed for a looked after child, the social worker has to personally attend the hospital to meet the consultant and sign the consent form.

Outcome 4 Care and welfare of people who use services

Parents of children whose disability is developmental delay rather than a more identifiable physical disability told us that health staff are slow to recognise their concerns about their child’s development. Once engaged with services however, parents are highly satisfied with the quality and responsiveness of the services their child receives and the support to themselves. This is particularly true of the multi-agency provision at the child development centre and the Mary Rose School where places are made available to children promptly on the identification of need.
Parents occasionally experience long waits when attending hospital appointments which can have a negative impact on children with disability and with autism particularly. Staff at The Portsmouth NHS Hospital Trust at Queen Alexandra Hospital recognised that improvements could be made and have taken positive action. A group of parents and children with autism are shortly to spend time at the paediatric emergency department to help staff gain a better understanding on how best to support these children in the hospital setting. Staff at the children’s assessment unit have introduced a more efficient case tracking system which has reduced waiting times significantly. Choices are given to older young people as to which services they access at the hospital and accordingly, some young people aged 18 with learning disabilities continued to be seen by the paediatric department.

Group sessions have recently been developed in services where groups of parents and children can be seen by several therapists on the same visit. This not only reduces the number of appointments the parents have to deal with and therefore means minimal upheaval for the child and this is the main benefit, but also helps to create capacity for the therapists to engage in the growing CAF, child protection and other multi-agency arrangements. Multiple appointments are avoided whenever possible and multiple procedures are undertaken under a single anaesthetic whenever possible. Parents appreciate this approach, one telling us about how her child had x-ray, blood tests and dental procedure all under a single anaesthesia.

The pathway into CAMHS and the Early Intervention & Prevention service is clear. CAMHS services are of high quality and have achieved national recognition from the Quality Network for Community CAMHS (QNCC). CAMHS workers are based with a number of specialist services including youth offending, substance misuse, sexual health and teenage pregnancy services. There are also workers in the team who have developed expertise in eating disorders and in working with asylum seekers. CAMHS and adult mental health work closely with planning for transition starting 3-6 months before age 18 and the care programme approach (CPA) can be introduced early where deemed helpful. Young people are encouraged to manage their own situation and condition and so reduce their vulnerability through the books on prescription scheme. Self-help books can be obtained from libraries on production of the prescription and web lists of books have been developed. The provision of tier 4 beds being outside the area at Winchester can result in children being placed at distance which can be detrimental to family and child and is under review at regional level. Practitioners make significant efforts to support children at home whenever possible.
17 Health staff in community and acute services are sensitive to supporting children, families and staff in dealing with difficult and emotional situations and have devised highly effective methods of alerting other professionals when these situations arise at the acute hospital or in the community nurses’ team offices. In order to alert colleagues that a family or child may be dealing with bereavement or equally difficult situation requiring additional quiet and sensitivity, a butterfly or rainbow picture is displayed on the entrance door. This is very effective in alerting other professionals coming into the department. Staff are aware of cultural perspectives of disability in minority communities and support asylum seeking parents who would be afraid to return to their country of original because of the cultural beliefs around children with disabilities and the likely impact of this on their child. Staff are also sensitive to working with families whose culture means they have particular expectations and practices around the end of life for a child. Workers themselves are well supported through debriefing and reflective sessions led by managers where these beliefs and practices raise challenging issues for them.

18 The teenage pregnancy rate is the second highest in the region and a comprehensive range of support services have been developed to address this issue. There are indications that these are achieving some success as numbers currently remain steady and under 16 year olds numbers have recently dropped. At the end of March 2010/11, ten girls were pregnant compared to 21 in the previous academic year 2009/10. Terminations rates are relatively low meaning pregnancies for this group are resulting in more live births. A wide range of innovative support and educative services and sexual health campaigns are in place which target boys as well as girls and which can be accessed easily by young people. Services include preventative support for 12-16 year olds and a positive outcomes for parenting teens service (POPT) as well as clinic and outreach services operating from the Ella Gordon Unit (EGU). Specialist midwifery and CAMHS work to promote attachment and re-integration is highly beneficial to teenage mothers and their on-going relationships with their baby. The introduction of family nurse partnership (FNP), into which health visitors and a midwife are to be seconded, will further enhance the array of services. Engaging young people as peer supporters to aid prevention is a good approach which could be further developed.
19 The centrally located Go For It centre, one of several, works very closely with other agencies supporting young people, including sex sense, G U Medicine, smoking cessation, youth and drug rehabilitation services. Services are successfully promoting long acting reversible contraceptives (LARC). Schools are aware of their teenage pregnancy data and are now making referrals into the Ella Gordon unit demonstrating that school engagement is increasing. One school facilitated implant insertion on school grounds and, through this intervention, the school has become very supportive. This has resulted in some other schools becoming more engaged with the strategy and one of the faith schools has joined the initiative. Educational visits to EGU with parental consent are now taking place. Sex sense also provides training for parents to better understand what sexual health services are delivering to schools. This is proving helpful in gaining parental support to the strategy. Feedback from young people engaged with these services is that their behaviour has changed as a consequence.

20 Looked after young people who become pregnant are also well supported by the local services. At the time of the inspection, there was one looked after child with a confirmed pregnancy and two care leavers, one of whom had been placed in Portsmouth from another area. These young people will be supported by the teenage pregnancy reintegration worker and the specialist teenage pregnancy midwifery service for up to 28 days post delivery who will refer to other specialist services if the young person needs further support. Services are flexible and can meet with the young person either at home, clinics, office base or a location of the young person’s choice as far as possible. This is of particular importance to young people in residential care where privacy could be an issue. Giving the choice of meeting place to the young person sometimes results in workers connecting with the young person’s friends with whom they can then engage in a preventative dialogue.

21 The new Children’s Outreach and Support Team (COAST) providing extended out of hours health support to children and young people in the community, is engaging effectively with other services and is well regarded. It aims to prevent a child’s admission into hospital and facilitate early discharge home. It is too early to identify any resultant reduction in child admissions as a result of the service.

22 Health take effective action to ensure that looked after children are healthy. The associate director for public health sits on the corporate parenting committee providing good connectivity between health and social care at a strategic level. The designated consultant paediatrician, lead clinicians and named nurses provide strong leadership and drive in ensuring that the health needs of individual looked after children are identified, appropriately addressed and monitored. Similarly, health ensures that good health records are maintained and the appropriate activity is undertaken for children going through adoption processes. Social care sends a weekly LAC cohort list to the LAC nurse to ensure that health are informed about these children. This process is generally followed and practitioners are proactive in chasing actions up if there are any delays.
23 Where children are placed out of area, the lead doctor tries to ensure a lead health practitioner is identified where the child is placed. Health assessments are widely shared with the relevant key stakeholders; the young person, foster carer, GP, SW etc and to any specialist who may be involved. Health assessments are sent to the young person for their comments and the format and content of health assessment forms has evolved over time with the influence of young people. Care leavers are given their latest health assessment and can come back to health later for more information or support up to the age of 21. Health leads are keen to maintain the quality of the health support given to children who are looked after with the merger of health organisations and inception of the GPCC.

24 Health assessments are undertaken by the paediatricians with the LAC nurses being responsible for the annual reviews. This ensures a consistent quality approach. In the past twelve months, 89.7% health reviews have been undertaken with an additional five per cent being adoption medicals totalling 94.7%. Strengths and difficulties questionnaires (SDQ) are updated annually for individual children enabling individual development to be monitored effectively. Children and young people who are competent are encouraged to complete these themselves; alternatively they are completed by a foster carer or a practitioner who is close to the child. Health has good information on individual children. The LAC nurse database shows immunisation records and dental visits are good. With the inception of Solent NHS, the LAC nurse from Southampton has recently taken up coverage of Portsmouth and will be the key liaison between health and social care on individual cases.

25 There could be closer integration between health and social care at the child’s annual social care review. New review preparation booklets for young people developed with the participation of the Children in Care Council (CICC) are useful, but make no reference to health. Inclusion of this aspect of the child’s wellbeing would facilitate the identification of health outcomes for the child at their annual review.
Outcome 6 Co-operating with others

26 There is a wide range of good quality health services for children and young people. Multi-agency working has improved over recent years and is now good. A positive culture of co-operation and partnership working has been developed across the key stakeholder agencies; health, social care, education and police. Community health services work cohesively across disciplines and with flexibility, giving choices to young people about how, when and where they access support. Specialist services such as physiotherapy, community children’s nurses and health visitors work closely with schools to support and train parents, carers and school staff to meet individual children’s complex needs within the home and school environment. Nurseries each have an assigned health visitor who makes regular contact. A Family Nurse Partnership service is to start in the autumn which will provide an additional facet to the existing range of services for young people who become parents. Specialist midwifery support for teenage mothers can continue to provide support for up to 28 days post birth. This service works closely and to good effect with other professionals including the CAMHS infant attachment worker, health visitors and outreach services. Monthly meetings between health visitors and CAMHS facilitate co-operative working.

27 Community health workers are well engaged with CAF, often holding lead professional responsibility and parents value the support that CAF arrangements afford them. Team around the child (TAC) work is increasing and demonstrating good health outcomes. Information across health and social care relating to CAF work with children could be further strengthened. School nurses do not always know that a CAF is in place until some weeks into their work with a child.

28 Continuing care arrangements for children are effective. The continuing care framework is viewed by staff as helpful and the continuing care working group, comprised of health, social care and education is operating well. Transitions into adulthood can be difficult with children and families support finishing at 18 and HV for children with complex needs finishing at 19. Until recently, few young people with complex needs survived into adulthood however this picture is changing and a transition pathway for this cohort is being developed. This work has been led by the lead nurse for adolescent health who has recently left. Recruitment to the role is in hand and no delay to the continuation of this development is expected.

29 End of life and palliative care services for children are in place as a children’s community nursing team (CCN) specialism and are working well. A nurse therapist who is part of the CAMHS team works with the CCN team one day per week to supports children and families in this situation as well as giving support to the nursing staff team. Local services work in close partnership with the nearest hospice located near Winchester, where families can also be supported after the child has died.
30 Children’s centres are offering high quality support to children with a variety of health and social care needs, often highly complex. Health visitors and other specialist community health support work closely with the centres to support children, parents and staff in meeting complex health needs and a jointly funded community children’s nurse post has recently been established at one of the centres to enhance the multi-disciplinary approach. The Child Development Centre provides highly effective multi-disciplinary support in a child centred approach, involving psychologists, SALT, OT and recently a specialist health visitor service.

31 Substance misuse services provide outcome focused support for young people. Treatment Outcome Profiles (TOPS), completed at treatment start, review and completion demonstrate that for 16+, provider services are achieving targets on changes in substance misuse, injecting behaviours and other activities which influence the quality of the young person’s life and impact on the wider community. Adapted TOPS have been developed to measure outcomes and there are plans to adapt these further. Outcome measures for the service focus on the young person completing treatment and reporting an improvement in their quality of life. There is also follow-up to monitor the young person 3-6 months after treatment.

32 Parenting groups for people with substance misuse aim to promote better outcomes for children and the service also uses strengths and difficulties questionnaires as a useful tool to help measure outcomes from intervention. The Think Family pilot in the adult substance misuse service ensures home visits are carried out for those identified as parents at the start of treatment. Further work is needed to ensure that the agreed protocol guiding adult mental health in identifying and responding to parents, is effectively applied. Early Intervention Grant Money is funding a substance misuse project worker to work with primary schools, undertaking both group work and some 1:1 sessions with children with identified substance misuse issues. This project however is only funded for six months although staff feel that early intervention and preventative work with primary schools is a gap in the longer term.
Information sharing across partner agencies regarding risks within a family has improved and is reported to be generally effective. This also applies to sharing information about potential risks to staff. Secure e-mail NHS.net is being trialled in Portsmouth and there are plans to roll out this out with social care locally and across Hampshire and Gosport. The trial indicates the system is helpful in transmitting post natal information and ensuring an audit trail. The new provision of RiO (health IT system) across all community health services is improving communication across services; risks and alerts can be shared more effectively. This is helping health professionals keep better track of health appointments relating to the child and pick up non attendance at appointments (DNAs) better. Data shows that non attendance at appointment is decreasing. Eg a case where there were 32 missed appointments for one child in total across a range of services including brain scan. The composite picture was built up through shared intelligence, child protection procedures initiated and a child protection plan put in place. Multi-disciplinary support to the mother successfully turned the situation around and after 3 months the protection plan could be lifted as the mother and child were well engaged with services. Where risks of DNA are identified, the specialist health visitor gives families a calendar, and keeps an identical one in order to both encourage and prompt attendance at appointments.

Good specialist services for LAC are in place. There is a specialist LAC health services team for children with disabilities with lead from the designated doctor. The LAC Health Team and the sexual health team work and liaise closely although the LAC nurses undertake most of the specific sexual health activities eg Chlamydia screening and accompanying young people to the GU clinic as appropriate. The young person can choose where they meet nurses eg Macdonalds or at the popular Go For It centre drop-in. Approaches are very individual and the nurses aim for flexibility. Health visitors undertake joint visits with the LAC nurses and one of the health visiting team acts as link worker for a specific group of foster carers. Staff feel this works very well in building trusting and supportive relationships which help placements remain stable. The CAMHS team for LAC consists of nurses, art therapist and until recently social care. The team give training, advice and guidance to foster carers aimed at placement stability. CAMHS staff are flexible in trying to meet the needs of foster children placed on the Isle of Wight as support is not given by IOW CAMHS.

The strategy for substance misuse and children’s homes is under review and there is scope to develop support across the looked after population. There is no specialist LAC substance misuse worker although the recent audit undertaken by health leads for LAC suggests there is a notable incidence of substance misuse among the LAC population. The LAC health leads will continue to collect the audit information annually. At present, the substance misuse service is not providing any training to foster carers.
There is a clear transition policy framing how young people move into adult mental health, with the exception of young people with autism or Asperger’s Syndrome for whom there is no pathway. Caseloads in the specialist LAC CAMHs team are high however, at 45 rather than 30, as young people are going through transition and adult social care is unable to take cases on at present. Generally, transition between CAMHS learning disability and adult learning disability works well but there can be difficulties where young people have profound disability and behaviour problems in finding appropriate support. Child and adult criteria differs so there can be a service gap for young people with lower levels of mental health need.

There is effective co-operative working between the acute services at the child assessment unit (CAU) and community health services. Staff at the CAU identify an increase in numbers of self-harming young people being referred to them potentially linked to current school exams and are able to alert school nurses to any specific trend developing in specific areas of the city. CAU also experience a good response from CAMHS when a child was identified as needing an assessment. They are able to phone a request through getting a prompt call back from the psychiatrist who then quickly attends for the assessment.

Outcome 7 Safeguarding

Health staff across all services have a clear understanding of safeguarding policies and thresholds and are making positive contributions to safeguarding children and young people. They are alert to the potential risk indicators they should look for in their routine contact with children and families and routinely use a range of checklists and registration forms to ensure that risks are identified and referrals to social care made promptly. Safeguarding designated and named practitioners provide effective leadership and direction across health services. They are accessible, provide practice based training, give helpful advice and guidance and are well connected with strategic and operational multi-agency arrangements and lead contacts. Lead professionals can escalate health safeguarding concerns if initial referrals are not taken up by social care, although not all frontline health staff are aware of this. Named nurses attend child protection conferences and CAF to support health staff where there are complex issues or stalling of progress. Lead professionals report a greater degree of accountability and challenge being developed within services. Health services work to You’re Welcome criteria and an increasing number of local services are being given accreditation following young people-led mystery shopping assessment.
Staff are aware of the work and decisions of the Portsmouth Safeguarding Children’s Board (PLSCB), child death overview panel (CDOP) and lessons arising from serious case reviews (SCR) and participate in action plans as required. The SCR processes have resulted in increased vigilance around identifying risk across health services. Regular newsletters and briefings are posted on health’s intranet and named nurses lead regular group supervision and practice reflection sessions where staff are kept informed of developments from these strategic bodies.

The CDOP is developing well as a conduit for practice learning and development. The panel posts an annual report to the LSCB website and has included safety information in the free newspaper (Flagship) sent to every household. The CDOP has driven effective campaigns resulting in very positive outcomes in a number of areas e.g. Safer Sleep campaign. This high profile local campaign included wide distribution of Safer Sleep Bibs and information packs. In the year prior to the campaign, there had been 21 sudden unexplained deaths. There was no incidence of sudden unexplained deaths the year following the campaign and a single incidence subsequently. Staff report improved midwifery practice has also resulted from the work of the CDOP with improved approaches to checking up on hand held records and sleeping arrangements for the new baby. As an additional result of the work of the CDOP, children who have died in the community are taken to the emergency department at QA hospital rather than to the mortuary which is less traumatic for families.

Health staff routinely participate in child protection procedures. Staff understand their roles and responsibilities in producing reports for conferences and are well supported by managers and lead professionals to undertake these. Reports are quality assured by clinical team leaders who are the safeguarding leads for their team before going to child protection conferences. Community children’s nurses and health visitors felt that the new local bruising protocol was very helpful in giving staff a clear framework and pathway for when they identify unexplained bruising. An initial surge of referrals has now settled down. Most staff are aware of it even if they have not had to use it. Staff from the Portsmouth Hospitals NHS Trust are able to feedback their experience of safeguarding processes to the named nurse giving them good opportunities to improve arrangements and practice. Health staff are aware of the whistle blowing policy.
42 There is a high level of awareness of risk identification at the single point of reception for adult and children’s emergency departments at the acute hospital (QA). Reception staff work through an eight checkpoint list of risk factors, checking with ambulance crews for any concerns. They talk to the child directly if appropriate and are attuned to the risk of misrepresentation of age. All children are checked against the child protection register and there is also a frequent presenters’ file which is checked routinely. A health visitor liaison service has to date undertaken a daily notes check of cause for concern forms to ensure all risks have been considered and to direct any cases accordingly. This is good practice. The health visitor liaison service will be completely withdrawn by October 2011, which could potentially result in delays in picking up any cause for concern issues.

43 Local facilities for children and young people who have been sexually assaulted are good. The sexual assault referral centre (SARC) offers a very high quality service, with follow-up, for young people who have been sexually assaulted. Younger children can be seen by community paediatricians in a discrete unit within the child assessment unit at QA Hospital; however this service is not available out of hours. Although there are small numbers of children to whom this applies, the issue has been recognised across the SHIP area as delays in these children receiving examination will be detrimental both to the child and potentially to criminal proceedings.

44 Midwives are effective in identifying risks relating to pregnant teenagers and their unborn child but find it can be difficult to get social care to develop plans pre-birth. This has improved with the involvement of the named midwife who meets monthly with senior social care managers to look at concerns about unborn children but there is scope to improve this further. The midwifery service has revised the questions asked at the time of booking to be more alert to safeguarding risks and more comprehensive, including whether a social worker is involved, any drug or alcohol misuse, a mental health history and location of previous children. Any disclosure of domestic violence is referred to the domestic violence project.

45 Adult mental health awareness around child protection issues has been raised significantly recently with a protocol in place to ensure appropriate referrals are made to the safeguarding team where there are children and young people whose parent is engaged with adult mental health services. Close attention is being given to ensuring consistent good practice in this area with the named nurse working with the adult mental health team.
Outcome 11 Safety, availability and suitability of equipment

46 There is a single reception area for adults and children attending the emergency departments at the acute hospital (QA). The single front reception area is rather austere with no provision to occupy or distract children who may accompany adults who require emergency treatment. This was the case on the day the inspector visited when several adults were waiting in reception to be seen and who were having some difficulties in occupying the children with them. In marked contrast, children needing emergency treatment are directed promptly through to the recently developed separate paediatric emergency department which presents an environment that is child friendly with observational play areas.

47 The children’s assessment unit (CAU) is recently built and provides a child friendly environment with play areas and pleasant décor. Reception staff are able to discretely observe the waiting area and also demonstrate a good awareness of risk indicators that they look for and check. A self-assessment form completed by parents forms an important part of the overall risk assessment. The play specialists on CAU and children’s wards provide an effective range of play linked interventions for a variety of reasons including bereavement for child and parents and end of life support for children and siblings. Staff on the CAU work effectively with colleagues in the community to support children in a multi-disciplinary approach eg a school recently alerted CAU about a domestic violence issue for a known family when they became aware of it, enabling staff at CAU to be more alert whenever this child attends CAU.

48 Equipment is available to disabled children, although community nurses have to make detailed business cases for complex items. Community children’s nurses take pads and equipment into schools so parents can easily collect them and provide training to staff to operate and maintain pieces of equipment whenever possible. Where a child needs interventions nurses try to fit around the child within their school to minimise disruption to the young person. They also provide an emergency service for equipment and train parents and carers as well as providing support to children’s centres where some children are supported who have very complex health needs.

Outcome 12 Staffing recruitment

49 Safeguarding is embedded in all areas of recruitment and selection, induction of staff and ongoing training and development. All appropriate staff under go enhanced CRB checks and reference sources are all checked. This now happens at the point of interview rather than at appointment so processes of appointment are much faster than previously. If internal acute hospital staff transfer into CED, the named lead nurse retrain them to level 3 to make sure standards are consistent. This is good practice.
Outcome 13 Staffing numbers

50 Managers acknowledge the challenge of achieving the target of health visitor resource by 2015 and are undertaking focused workforce planning to support this delivery. One objective is to retain the experienced staff they currently have and explore new ways of working to grow newly skilled staff. Some health visitors will be seconded into the new Family Nurse Partnership service currently being developed. The service will need 28.5 FTE health visitors in 2015.

51 Numbers of community midwives are considered sufficient but currently their deployment is being retargeted where it is most needed. This should release time to give to safeguarding activity and core tasks.

52 No concerns were raised regarding the provision of appropriately trained and experienced staff during the inspection.

Outcome 14 Staffing support

53 There is a strong emphasis on annual safeguarding training across all health services at appropriate levels; attendance is closely monitored. Staff consider the training to be of high quality and can identify improvements in practice as a result. Topic based professional forums for safeguarding leads have been established and are valued as opportunities for support and professional development. Safeguarding champions are identified in all services who meet regularly to look at research and briefings. Safeguarding audit findings are taken to this forum. Named nurses hold practice reflection meetings as required to enable practitioners to evaluate and reflect on specific complex cases and develop practice improvements. Staff value these sessions highly. The focus on training in health over the past three years has raised awareness levels and safeguarding practice significantly from a low base. There is a risk of an over-reliance on safeguarding training, particularly in acute services, as the sole measure that arrangements are effective in the absence of a performance management/objective setting approach.

54 A robust approach to professional development in primary care is in place. All GP practices are contracted to participate in “Target”, an afternoon per month training session at the football club regularly focusing on safeguarding issues. There is potential to use these forums to develop stronger links between primary care and the health visitor service since they are no longer based in GP practices. There is a view among GPs that they are less well engaged with health visitor work since this change. Whereas MARAC and MAPPA are well understood by most health services, GP awareness of these arrangements is low.
55. Reorganisations of health and social care have impeded progress on some areas such as the LAC lead professionals quarterly good practice forum has not met for some time and is to be reconvened imminently. The vacancy in the role of designated nurse for LAC since July 2010 has stalled some aspects of LAC and Being Healthy, however this post has now been filled and the new LAC nurse will start shortly.

56. Supervision arrangements combining group and individual sessions are adequate overall, but there are some gaps. Also some external supervision is in place as required by specialist groups of staff. Safeguarding is not necessarily a standing item for discussion in supervision in some services and managers acknowledge this gap. Although there is not yet a regular safeguarding discussion and practice development forum at QA hospital, the Friday lunchtime information meeting (FLIM) is an established forum where news and important information is shared and is open to all QA staff. This forum has been used to share findings and lessons from SCR. Staff at the hospital also cite the hospital chaplaincy service as being highly supportive to staff with a good visibility around the wards. A weekly joint academic session for safeguarding leads is led by the nurse consultant using case studies and topic based discussions. This is a useful developmental forum. Safeguarding supervision and mentoring was not in place for all named consultants and should be addressed.

Outcome 16 Audit and monitoring

57. There is not yet a robust performance management framework governing safeguarding activity across health services and quality assurance monitoring is underdeveloped. While the focus over the recent past has been on raising awareness and ensuring that health staff are trained to the appropriate level, this is insufficient to fully assure the LSCB that health’s performance on safeguarding is robust. The PCT children’s safeguarding board has not yet set out a work programme for health services that will drive targeted improvements in acute and community health services and set out measurable objectives against which services can develop their own specific improvement agenda.

58. The acute trust’s children’s safeguarding committee has representation from most although not all hospital departments. The committee produces an annual report which includes national policy changes, research findings and notifications to CQC but has not yet included a full list of measurable objectives to direct the work programme of the safeguarding team for the following year as part of an overall strategy. Data is collected to monitor numbers and types of safeguarding referrals being made and reported to the governance committee. An audit of safeguarding referrals originating from health has recently been undertaken and work is underway to develop a tool to improve the quality of referrals. The hospital has undertaken a section 11 audit using the LSCB audit tool.
There is scope to develop a more comprehensive, composite picture of the health of the cohort of LAC children through audit and collation of information from SDQs and through further development of learning from the substance misuse audit and others. Young people have contributed to surveys about how their health needs are being met and other health audits have resulted in service improvements. To date no annual report on the health of LAC and how effectively health has delivered good health and wellbeing outcomes for this group of young people, has been produced.

Information governance arrangements are good across health. All Solent NHS staff have access to secure e-mail. A multi-disciplinary approach is taken in the CAU at the acute hospital to auditing and quality monitoring records and documentation. A recent documentation audit included parents’ admission questionnaires, feedback from which is explored in team meetings for service improvement opportunities.

Targeted campaigns to address local health challenges demonstrate some successes in areas such as the introduction of routine CO2 monitoring of pregnant women in a high smoking and drinking culture. Although there is more to achieve in this area, numbers of pregnant women who smoke are reducing. Similar locality targeted work to encourage breast feeding is showing some success.

Outcome 20 Notification of other incidents

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

Outcome 21 Records

Health records for looked after children are generally well ordered and maintained. A clear protocol is in place and effective governing how social care send health written notification of all children who are received in to care, changed placement or left care. As a contingency social care send a weekly list to the LAC nurse to ensure that health are fully informed about these children.
There is a database of health assessments and immunisation records maintained by the previous LAC nurse. Since the post holder left in July 2010, there has been a hiatus in the maintenance of the database. The previous lead also did a quarterly report for the corporate parenting board and ensured attention was given to dental treatment, giving out dental packs which has also been temporarily in abeyance. Aspects of the post have been covered temporarily and a new post holder will be taking up the role shortly.

Recommendations

Within 3 months (from report)

*NHS Portsmouth (The SHIP Cluster) and Solent NHS Trust with Portsmouth City Council should ensure that the health aspects of the wellbeing of looked after children are addressed at individual children’s annual review.* (Ofsted May 2011)

*NHS Portsmouth, The SHIP Cluster, Portsmouth Hospitals NHS Trust and Solent NHS Trust should take action to develop a robust performance management and quality assurance approach to ensuring the continuous improvement of health’s contribution to children’s safeguarding arrangements; this should include the setting and monitoring of measurable outcome objectives as part of health’s LSCB annual reporting system.* (Ofsted May 2011)

*NHS Portsmouth (The SHIP Cluster) and Solent NHS Trust with Portsmouth City Council should ensure that the review of the strategy for substance misuse includes consideration of the findings of the recent health audit and is extended to include the support needs of foster parents.* (Ofsted May 2011)

Health in partnership with social care should ensure effective information sharing in relation to CAF work with individual children.

Health should ensure that safeguarding supervision and mentoring arrangements for individuals and teams are fully established and effective across community and acute services and that children’s safeguarding is consistently addressed in adult services’ supervision and performance management arrangements.

Within 6 months

*NHS Portsmouth (The SHIP Cluster), Solent NHS Trust should develop the engagement and participation of looked after young people in the recruitment of designated and named professionals, quality assurance and audit processes and on-going service development.* (Ofsted May 2011)
Next steps

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