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

Date of Inspection	**3rd October 2011 – 14th October 2011**
Date of final Report	**18th November 2011**
Commissioning PCT	**NHS Brent**
CQC Inspector name	**Ms Jan Clark**
Provider Services Included:	**Integrated Care Organisation (ICO), incorporating Ealing Hospital NHS Trust and Community Services Brent**
CQC Region	**London**
CQC Regional Director	**Mr Colin Hough**

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 .

Brent Borough Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
The contribution of health agencies to keeping children and young people safe	Adequate
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	Good
Being Healthy	Inadequate

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:

London Borough of Brent has a resident population of approximately 74,000 children and young people aged 0 to 18, representing 23% of the total population of the area. In 2011, 91.7% of the school population was classified as belonging to an ethnic group other than White British, compared to 22.5% in England overall. About 60% of pupils speak English as an additional language. Gujarati, Somali and Arabic are recorded as the most commonly spoken community languages in Brent schools. Large and established communities of Indian, Black Caribbean and Irish people live in Brent. However, the proportion of children from these backgrounds is decreasing. The numbers of children from Somali and other Black African groups, Eastern European, Afghanistani, Iraqi and Hispanic backgrounds are increasing.

The Brent Children's Partnership, which was originally constituted in 2005 under former Children's Trust arrangements brings together key agencies within the public, community and voluntary sectors who have responsibility for the development, implementation and monitoring of the Brent Children and Young People's Plan. A Partnership Board Executive is responsible for the development and monitoring of the plan. A Partnership Forum, which includes agencies such as the police, Brent Primary Care Trust, the probation service and Brent Youth Parliament, has responsibility for the delivery of the plan. The Brent Local Safeguarding Children Board (LSCB) became independently chaired in 2006, bringing together the main organisations working with children, young people and families in the area that provide safeguarding services.

At the time of the inspection 384 children were looked after, comprising 64 children of less than five years of age, 198 children of school age (5–16), 122 post-16 young people and a total of 153 with care leaver status, of which 30 are currently at university. At the time of the inspection 240 children (107 females, 131 males and two unborn children) were subject to a child protection plan, and this figure has increased over the last two years. Some 34% of these children are aged under five, 1% are unborn, 48% are aged five to 11 and 17% are aged 12 years or older. The highest categories of registration are emotional abuse at 55% and neglect at 38%, with physical abuse at 5% and sexual abuse at 2%.

Commissioning and planning of health services in primary care are carried out by the Primary Care Trust (NHS Brent), with the main delivery of community health services being through Community Services Brent (part of Ealing Hospital NHS Trust). The main provider of acute hospital services is North West London Hospital Trust. Community-based child and adolescent mental health services (CAMHS) are provided by Central and North West London NHS Foundation Trust. In-patient CAMHS (Tier 4 services) are externally commissioned by NHS Brent. The Primary Care Trust (PCT) recently joined with NHS Harrow to form a sub-cluster with the overall North West London cluster of eight PCTs.

Universal services such as health visiting, school nursing and paediatric therapies are delivered primarily by the Community Services Brent directorate of the Ealing Hospital NHS Trust. Community Services Brent (CSB) merged with Ealing Hospital NHS Trust and the community services from Harrow and Ealing to form an Integrated Care Organisation (ICO) in April 2011.

The acute hospital trust providing accident and emergency services for children and young people in Brent is North West London Hospitals Trust (NWLHT). Accident and emergency services are provided at the Northwick Park Hospital site and Central Middlesex Hospital. Maternity and newborn services are provided by NWLHT and Imperial College Healthcare NHS Trust. Children and families access primary care services through one of 70 GP practices, walk-in centres (including the walk in service at the Wembley Centre for Health and Care) and urgent care centres/minor injury centres at Northwick Park Hospital (provided by Ealing Hospital NHS Trust) and Central Middlesex Hospital (provided by Care UK). Services for children with learning difficulties and/or disabilities and who have complex health needs services are provided by Community Services Brent.

General – leadership and management

1 NHS Brent is developing its approach to ensuring effective delivery of children's safeguarding across health provider services and delivering good outcomes for looked after children following the transformation of local health services in 2011 and is ambitious to drive improvements. Health's contribution to safeguarding is good. A safeguarding commissioning and performance monitoring policy is in final draft and is to be ratified at the next LSCB. Since moving into a more commissioning focused role, capacity in the safeguarding team has been increased with additional sessions allocated to the designated doctor. The delivery of training and increasing the engagement of GPs, dentists, opticians and other primary care services is a priority area of work. As the designated nurse took up post in March 2011 following a period of interim cover, the team is in the process of becoming established and developing the new performance management relationships with named professionals and providers.

2 Delivery for the Being Healthy outcome for looked after children (LAC) is inadequate, however. In 2010, there was a significant failure in the completion of initial and review health assessments and a large backlog developed reaching 179 in October 2010. A new designated LAC nurse came into post in January 2011 and capacity with the LAC health team was increased in May with the appointment of a named LAC nurse. An action plan was put in place and the new LAC team, with the designated doctor, have reduced the backlog of initial health assessments to 17 against the action plan target of 10. There were 39 outstanding health reviews for LAC at the time of the inspection. Although performance is improving there remain significant areas for development, not least in achieving accurate and agreed data with social care. There is no health presence on the corporate parenting board and the LAC health team have little or no awareness of this body or its role and purpose.

3 There is not yet a comprehensive performance management framework in place to ensure the provider's (Ealing Hospital Trust, Community Services Brent) effective internal governance of its delivery of the Being Healthy outcome. Following the creation of the ICO in April 2011 there has been a review of the governance arrangements for LAC. Locally it is overseen at the Community Services Brent Safeguarding Children and LAC Group which has recently been established and reports to the ICO Safeguarding Children's Group which, in turn, reports to the ICO Clinical Governance Committee and so to the Trust Board. Within Ealing Hospital NHS Trust, scrutiny of the service is being moved to sit with safeguarding in the clinical governance arrangements. This should deliver greater governance rigor.

4 NHS Brent in partnership with Brent Children's services recognises that there is significant development needed to ensure that outcomes for LAC are consistently positive and that all aspects of service are in place and effective. The LAC service is now jointly commissioned and the borough director in the PCT and the lead social care manager are working closely to develop a shared understanding and agreement about effective performance monitoring arrangements and to put these in place.

5 A new LAC strategy and specification is due to be implemented imminently. This has been developed with the involvement of young people. The safeguarding children's commissioning policy sets clear requirements on providers regarding provision for LAC. Discussions about the findings of the inspection to date have taken place between the PCT borough director and the provider senior managers and an action plan to address deficits has been developed. There has been prompt action and commissioners express confidence in the new leadership of CSB.

<u>Outcome 1 Involving Users</u>

6 Engagement of young people in the commissioning, improvement and delivery of health services is underdeveloped. While there has been engagement and consultation in specific service areas, there is significant scope to improve. There is no Young Inspectors or mystery shopping programme to evaluate services against the You're Welcome criteria and young people are not engaged in training or recruitment of health personnel. Young people had little choice in where their health assessments and reviews are conducted and lead professionals recognised facilities most used were very clinical.

7 Disabled care leavers can be supported up to age 23 years but health support to care leavers overall, is also under developed. The information leaflet currently in use is outdated and has not been developed with young people's involvement. No comprehensive health information is yet available in a young person friendly format. Final health assessments are undertaken by the looked after children (LAC) nurses but these may take place up to almost a year before the young person leaves care so there is no health "exit" interview and key health actions could be missed. Work is at an early stage between health and social care to develop health passports for care leavers in partnership with young people.

8 Parents of children with disabilities also do not feel engaged in any meaningful discussions with health or social care about service development to meet the needs of their children more sensitively or effectively and are frustrated by the lack of response they experience to requests for greater, meaningful consultation.

Outcome 2 Consent

9 Within both the acute and mental health provider trusts there are appropriate policies and procedures in place that ensure consent is taken prior to any treatment of children and young people. Consent is gained from parents and carers and is appropriately documented. Consent to undertake health assessment is obtained by the LAC health team in accordance with the Department of Health's Guidance.

Outcome 4 Care and welfare of people who use services

10 The Urgent Care Centre (UCC) operating at CMH by Care UK to provide 24/7 acute health services since March 2011 has had a significant impact on the attendance of children in the paediatric assessment unit (PAU) at CMH, effectively treating 9 in 10 of all children coming to the hospital for an emergency with less than one child per day then being admitted to the PAU, representing an 88% reduction in attendances. As a result of this, a review of the configuration of paediatric service provision across the acute trust sites was underway at the time of the inspection.

11 Child and adolescent mental health (CAMHS) services are accessible, of high quality and are well regarded across the partnership. Operational co-operation between CAMHS and adult services is positive with a number of case examples demonstrating effective working to safeguard children. There is a protocol for out of hours services to children needing CAMHS assessments operating across eight boroughs. These arrangements are being reviewed by commissioners in a multi-agency partnership as part of the overall review of paediatric pathways following the expected closure of the paediatric assessment unit at CMH.

12 While there is some effective multi-disciplinary health provision for children with complex health needs and some positive outcomes for some individuals, this is not consistent. Initial health assessments (IHAs) and health reviews (RHAs) are not routinely completed within timescales with 10% falling outside the four week requirement. Overall for looked after children, the quality of initial health assessments and review health assessments is variable; some are very basic even when carried out by consultant paediatricians while others are very comprehensive. Health plans are not sufficiently or consistently outcome focused, being mostly identifying tasks to be done such as attendance at clinics. The voice of the child and evidence of their active participation and choices, where competent, is not strongly evidenced in the record. While e-safety is reported as being a routine area for discussion at reviews, the inspection audit did not identify this. There is no robust approach to monitoring actions identified in health plans. Most RHA (non complex) are undertaken by health visitor or school nurses. The LAC team administrator alerts the health visitor or school nurse to the due date for a review but there is no effective mechanism to ensure the review is undertaken. Given the capacity issues within health visitor service, this creates risk that reviews can be missed, as demonstrated by one of four case records examined. The designated doctor, named nurse and administrator all have access to the health LAC database (spreadsheet). It is only the administrator however, that has a token to access the social services LAC database. This is of concern as the system is therefore overly dependent on one individual.

13 There is a good range of sexual health services; GUM and community service from CMWL and GP services and others commissioned from the voluntary sector. Performance is improving and mostly positive. Schools are well engaged with the sexual health agenda and there are some specialist services working with specific community groups to address locally identified issues such as female genital mutilation.

14 Teenage pregnancies figures for looked after children and care leavers in Sept 2011 are high. The LAC population at the time of the inspection stood at 322 with 184 care leavers. Of the 65 young people aged 13-18yrs, 1 is pregnant, 8 are mothers representing 13.8% of the cohort. For the 66 aged 18-21yrs, 2 are pregnant and 25 are mothers, representing 40.9% and for the 14 care leavers aged over 21yrs, 3 are mothers representing 21.4%. Similarly there is a notable incidence of parenthood within the male looked after population with seven looked after young men aged between 13 and 21 years are either fathers or expectant fathers. No targeted health promotion programmes are being delivered to the LAC by the designated or named nurses as part of any preventative strategy however; the team has been addressing the backlog of health assessments as the priority. A sexual health advisor, employed by Brent council, delivers sexual health advice and support to some individual young people who are looked after and has delivered a programme of sexual health workshops but currently there is no joint work with the LAC nurse team.

15 There are some specialist CAMHS services for LAC which are psychological in nature including a play therapist employed by Brent social care and based with the CAMHS service. The LAC CAMHS service provides very supportive programmes to foster carers and advice and guidance to social workers and carers which is highly valued, successfully sustaining placements at risk of breakdown. Foster carers can self-refer or go through their social worker but not all foster carers know about the service. The service participates in foster carer training and events, delivering sessions which are well received.

16 Substance misuse services commissioned from AD Action are good quality and well regarded. The young person is in control of their support plan being assisted to use a range of self-assessment tools to identify their needs and goals. Treatment Outcome Profiles (TOPS), completed at treatment start, review and completion demonstrate that the service is delivering good outcomes.

17 Health is very closely engaged with education at all levels on a range of healthy lifestyle initiatives which contribute to the safeguarding of young people. These include sexual health education and the Healthy Schools programme is being continued in the borough with 23 funded projects going forward. These include programmes on healthy eating, health & wellbeing and physical activity and will be independently evaluated next year.

Outcome 6 Co-operating with others

18 Health practitioners are increasingly participating in child protection processes, with community midwives being individually supported in doing this by the specialist midwife for safeguarding. While thresholds for child protection referrals are generally understood, the level of contact with the out of hours emergency duty team by A&E staff suggests further development in this area would be beneficial.

19 There are poor arrangements between social care and health for information exchange, in relation to looked after children. The LAC nurses have no access to the social care information system, Framework i. There is no shared database with social care and with constantly changing numbers and inconsistent information conveyance by different social care locality teams, the LAC health team is challenged in developing a clear profile of the health needs of the LAC cohort. Where children are identified as being placed out of area, the LAC nurses liaise effectively with their health colleagues in the placement area to ensure the child's health needs are identified and met, if the child cannot easily be seen in Brent. Where the required service is not available locally to the child, NHS Brent will commission services privately. While there is no evidence that the health needs of children placed out of area are not being met, there is a priority need to improve information exchange between the partners.

20 The social care LAC review and health assessment and review systems are disconnected and this is a significant barrier to ensuring good outcomes for young people in care. The designated and named nurse are not routinely informed of or invited to LAC reviews; health visitors and school nurses are only invited by some locality teams. LAC minutes are not shared with the LAC nursing team. This is particularly of concern where there may be complex health issues that should be addressed in a multi-disciplinary approach.

21 Multi agency risk assessment conference (MARAC) meetings addressing domestic violence issues relating to individual families are well attended by agencies and arrangements work well. Relationships with police are positive. The health visitor liaison service provided by CSB at the acute trust which acts as an effective conduit across community and acute services, also acts as the health link on MARAC. Some GPs and primary care services are unaware of MARAC however, and are not engaged with the MARAC arrangements, although awareness in primary care of domestic violence as an issue and the resulting risks to children is increasing.

22 Transitions from children's service into adult provision generally work well with conditions for which pathways may not be clear, such as sickle cell anaemia, being scrutinised by the LSCB. Planning for transition in CAMHS starts six months prior to transfer and liaison with adult services on individual children is effective.

23 While there is some evidence that hearing impaired children have positive experiences of health services, parents of learning disabled, autistic and ADHD children do not feel their children are well supported by health and social care services. Examples cited include; difficulties in accessing OT assessments for inclusion in statements, lack of effective transfer of information about their child's needs between hospital services and the lack of effectiveness of health passports for those who had them. There is no evidence of an effective approach to co-ordinated health planning between disciplines so that multiple interventions can routinely be achieved under a single appointment or anaesthetic. Workers are able to present individual complex needs cases to a resources panel which has recently become multi-agency with the inclusion of the lead paediatric physiotherapist for additional resources. Assessments brought to panel are not always fully comprehensive or multi-disciplinary however potentially reducing the likelihood of the best outcome for the child.

Outcome 7 Safeguarding

24 Health staff are aware of their safeguarding responsibilities and make appropriate referrals, with sound risk assessment awareness and appropriately probing questions asked by reception staff in acute services when children and young people present for treatment. Staff have identified people purporting to be considerably younger than they are and have also identified missing children from another authority. The very effective health visitor liaison service which operates across both acute hospital sites has been extended to include the UCC and these effective quality assurance arrangements remain under review. Activity and outcomes arising from the health visitor liaison are reported through the Community Services Brent annual report. When the health visitor liaison is absent, staff are aware of how to raise concerns and seek advice but no backfill cover is in place to maintain the level of quality assurance across the three sites at those times.

25 Helpfully, Brent social care send health services updated information on children on protection plans and those who are looked after although the frequency of this information being sent to health services is not consistent. It is conveyed daily to the hospital trust and entered onto the patient database which operates across both NPH and CMH. An effective IT flagging system is in place and improvements are being implemented such that hospital discharges cannot be authorised until key information has been entered onto the system. This will improve the rigor around safeguarding risk assessment and management at the acute trust. Updates of child protection and looked after lists are sent to the Care UK urgent care centre weekly and to primary care practices on a fortnightly basis. Although this information is only one strand of effective risk assessment, it is unclear why different practices are operating as this creates potential risk that recent registrations will be missed. Due to different, non-interfacing information systems across health services, it is not easy for health to promptly identify children who may present frequently across different services. Frequent presentations across the health economy are identified by GPs receiving post-presentation notifications, highlighting the importance of primary care's role in a complex health environment.

26 Named doctors and nurses in provider are accessible and regarded as being able to give sound safeguarding advice and support. The designated doctor and nurse supervise named professionals and are actively engaged with provider services in acute, community and primary care practices. They are working closely with their colleagues in neighbouring boroughs to develop a collaborative model across authority boundaries. The safeguarding designated and named professionals disseminate information and briefings from LSCB, CDOP and SCRs throughout services and there is evidence of lessons learned from significant and serious incidents, nationally and locally, informing the development of improved frontline safeguarding practice. These key groups do not have high profiles however and not all frontline staff across acute, community and primary care are aware of them.

27 Dentists and GPs are increasingly engaged in safeguarding arrangements. Practices are well connected with the designated doctor and nurse who provide targeted training, advice and guidance. GPs find it difficult to attend child protection meetings and conferences as these are usually scheduled during surgery times but prioritise the submission of reports. They are kept well informed of child protection meetings and outcomes, receiving detailed minutes of meetings routinely. Routine primary care meetings for practice staff include child safeguarding as a standing agenda item. These weekly or monthly meetings are regularly attended by health visitors. Work is underway involving a practice manager and social care to develop a flowchart to assist GPs in cases where there may be questions about parental responsibility on registering a child at the practice. This is a particular local challenge due to children from overseas presenting at practices accompanied by a sibling or person other than their parent. There is no named doctor at present. GPs recognise this is a gap as they are not directly represented on the LSCB.

28 Adult services staff who support adults with mental health or substance misuse issues are aware of risks to children of hidden harm within these households. Staff in adult services undertake regular child safeguarding training at appropriate levels and work closely with social care colleagues, who regularly attend their team meetings where child safeguarding is a standing agenda item. In-patient adult mental health services are also well attuned to issues around the potential for hidden harm to young people and have effective policies in place in relation to children visiting adult's receiving in-patient treatment.

29 Pre-birth planning is improving although there is work to do to achieve consistently effective action across all areas of the borough. There are examples of good practice where early planning has achieved positive outcomes. Midwives were not attending pre-birth planning meetings for a period of time last year due to staff sickness. This is now resolved and maternity services have been present at all pre-birth planning meetings since December 2010. Teenagers who are pregnant are well supported by the specialist teenage pregnancy midwife who provides group and 1:1 classes for teenagers and looked after young people who are pregnant booked at NPH. The reconfiguration of community midwifery services into children's centre based teams is expected to facilitate more local access for pregnant teenagers to this specialist support.

30 Sexual assault services are established and effective. There is a dedicated suite at NPH and all cases requiring further acute service are transferred to The Haven sexual assault referral centre (SARC) at St Mary's hospital. Appropriate post-traumatic follow-up support and sexual health services are in place for young people when they return to the borough. There is a well regarded GUM clinic at CMH and an effective link to CAMHs. The designated doctor for safeguarding is part of the child protection rota working closely with specialists in forensic services and clear pre-trial protocols are now in place as a lesson learnt from a serious incident elsewhere. A lack of understanding of this pathway within the UCC at Central Middlesex Hospital (CMH) which created some difficulties earlier in the year have been resolved and recent case examples have reaffirmed the effectiveness of this pathway.

31 Where young people need to be admitted to a clinical setting for mental health treatment, Tier 4 beds provision at The Priory in Roehampton operates across number of boroughs in a consortium arrangement. Use of a specific bed with agreed special arrangements can be used in a particular adult ward but is very rare and there have been none in the last quarter. In addition to notification to CQC, a daily report of usage if the bed is occupied is required by the commissioners. This is a recent strengthening of contract arrangements. Practitioners can make individual cases for children to be admitted to alternative provisions to best meet individual need but this can be difficult to resolve as across North London, Tier 4 provision has been reduced.

Outcome 11 Safety, availability and suitability of equipment

32 Both Northwick Park Hospital (NPH) and Central Middlesex Hospital (CMH) have urgent care centres (UCC) as the initial, single point of access for children and young people seeking emergency medical treatment, from which on registration and triage, children are promptly moved into discrete paediatric treatment areas if necessary. Arrangement are clear but the UCC reception area at CMH and the positioning of reception staff is not ideal to ensure good observation of the waiting area and main access door.

33 No issues were raised during the inspection relating to the provision of equipment for disabled children. School nurses and other specialist practitioners are able to provide support to school staff and to parents on the use and maintenance of special equipment.

Outcome 12 Staffing recruitment

34 Health staff across provider services are CRB at enhanced levels on recruitment in line with minimum national requirements.

Outcome 13 Staffing numbers

35 Health visitors prioritise child protection activity, have a high level of awareness about risk assessment and take appropriate action to make children safe. They always attend core groups and conferences as required and are maintaining close working relations with primary care and acute hospital services and are well supported by operational managers. In order to achieve this performance within the current context of levels of vacancies across the service however, staff are voluntarily working additional hours in evenings and at weekends and this is putting individuals and the service under pressure. Staff are finding it difficult to achieve the 14 day new birth visit target, although performance in this area improved last year and while it has been routine practice for health visitors to feedback to acute services the outcomes of actions taken, this now happens rarely. Other services such as community nurses, physiotherapists, SALT and occupational therapists are extending their roles to take on some tasks which health visitors lack the capacity to undertake, including health and wellbeing talks to ethnic communities. School nurses and health visitors are currently unable to provide sex education clinics in schools due to the capacity issues resulting in variable provision across the borough.

36 Positively, the service has widened its recruitment remit and following a successful recent recruitment, the vacancy level will reduce to 5 whole time equivalents by November. There has also been a good uptake of student health visitor places recently. Skill mixing is also developing within the service, extending the roles and skills of nursery nurses to take on some preventative work and public health promotion in areas of deprivation and identified high vulnerability and potential risk. Work is at an early stage to map current services against needs in order to develop a strategy to build capacity and deliver on national 2015 targets and this is a key area for development.

37 No concerns were raised during the inspection regarding the provision of appropriately trained and experienced staff and paediatric expertise at the acute hospitals.

Outcome 14 Staffing support

38 Safeguarding training is in place across community services at appropriate levels. While safeguarding training at the appropriate levels is in place for the most part, there are some gaps identified at the acute hospital trust where not all non-clinical frontline staff had received recent update training. Awareness of their safeguarding responsibilities among this cohort is high however and there is no evidence of children being put at risk.

39 Managers within the acute trust are aware of the need to secure training and updating arrangements and are prioritising this; it remains an area for development however. Supervision arrangements are in place for clinical staff across services. Arrangements for regular reflective practice sessions are also in place but these arrangements are not currently addressing the needs of non-clinical staff.

40 Support arrangements for safeguarding designated and named professionals are in place and these staff feel well supported by managers and through peer review and other local and regional forums.

Outcome 16 Audit and monitoring

41 New service specifications and a performance management framework to encompass safeguarding and health of LAC activity and outcomes is being put into place by NHS Brent, but is not yet in place. NHS Brent is continuing to strengthen its approach to performance management and the relationship it has with providers and is self-aware about areas needing development. Progress is being made and there is close working between the PCT and social care to address areas for improvement, but there is a clear recognition that there is more to do before arrangements are fully effective across the whole economy. The March 2011 health of looked after children annual report includes data reflecting national statistical data on LAC but is light on local LAC population data.

42 There is significant improvement in performance on key child and young people's health outcome areas, although some remain challenging. Chlamydia screening rates in GP practices have been best in London for four years and are the best in the country currently. The Human Papillomavirus Vaccine programme at 82.7% compares well with neighbours, being third best in London last year and up by 3% this year. The focus on early years' health & wellbeing is improving GP access and registration, with effective signposting of people to practices which can best meet their cultural and language needs. Eighty-eight percent of young people are accessing dental health care. Despite fast tracking young people needing immunisations at GP practices and positive immunisation performance for young people as a whole, only 57.6% of looked after children had up to date immunisation, a drop in performance since 2008/09 when this stood at 71.4% and 69.5% in 2009/10.

43 The contract at CMH with Care UK to provide UCC services has been in place since March 2011. A baseline audit of performance was taken by the designated nurse in April and some concerns about performance identified and addressed through increased commissioner monitoring arrangements. While there are still areas for development particularly when there are surges in patient numbers at times, performance is improving.

Outcome 20 Notification of other incidents

44 NHS Brent, acute and mental health trusts have satisfactory arrangements in place to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC. Staff across health services report being aware of whistle blowing procedures within their organisations.

Outcome 21 Records

45 Quality of recording practice generally is also an area for development to ensure consistent good practice as this was not evidenced in the LAC case sample inspected. Some clinical notes in LAC records are undated and not signed, some health assessments are illegible and authorship cannot easily be determined. It is not clear that ethnicity and cultural issues are being fully identified and addressed from the case record, although evidence from practice suggests that this is addressed. There is no evidence of routine record auditing although the designated and named nurse have recently undertaken an audit, this has yet to be written up and has not yet had an impact. There are no strengths and difficulties questionnaires (SDQs), developed by social care, on the health records and therefore an opportunity to use these to map the child's personal growth and development and involve the young person in this activity, is being missed.

Recommendations

Immediately

- *NHS Brent to provide an effective health service to looked after children:*

  - *to ensure the timely completion of all health assessments and reviews*

  - *to develop a robust approach to monitoring actions identified in health plans*

  - *to improve information exchange between health and social care professionals*

  - *to provide age appropriate and comprehensive health information for looked after children*

  - *where appropriate, to ensure that health professionals are invited to or able to contribute effectively to looked after children reviews*

  (Ofsted November 2011)

- NHS Brent and Ealing Hospital NHS Trust to ensure that clinical recording practice is of good quality and subject to regular audit and reporting arrangements.

- NHS Brent and Ealing Hospital NHS Trust to ensure that young people are fully engaged in the development and delivery of an effective service for looked after children.

Within 3 months (from report)

- *NW London NHS Trust to ensure that safeguarding thresholds are clearly understood. The Trust also to ensure that appropriate child protection and safeguarding training and regular updates are in place for all staff, and that attendance and impact on practice are monitored effectively*
  (Ofsted November 2011)

- *NHS Brent to put in place a performance management framework to fully encompass providers' safeguarding activity and outcomes and monitor this routinely through effective clinical governance arrangements*
  (Ofsted November 2011)

- *Ealing Hospital NHS Trust to develop a workforce development plan for the health visitor service which aligns with national 2015 targets*
  (Ofsted November 2011)

- *NHS Brent to ensure that general practitioners are fully engaged with multi-agency risk assessment conference (MARAC) arrangements*
  (Ofsted November 2011)

- *Brent children's social care services, NHS Brent and Ealing Hospital NHS Trust to put in place consistent and effective arrangements to ensure the prompt sharing of information about children subject to child protection plans and children who are looked after*
  (Ofsted November 2011)

- *Brent children's social care services, NHS Brent and Ealing Hospital NHS Trust to ensure that disabled children and young people and their parents/carers are actively engaged in the quality assurance and development of services.*
  (Ofsted November 2011)

Within 6 months

- NHS Brent and Ealing Hospital NHS Trust to ensure that health promotion programmes for young people, including programmes focused on the needs of young people who are looked after, are in place to support the delivery of commissioners' strategic objectives.

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.