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

Date of Inspection	**28th November 2011 – 9th December 2011**
Date of final Report	**25th January 2012**
Commissioning PCT	**NHS Leicester, Leicestershire and Rutland Cluster**
CQC Inspector name	**Tina Welford**
Provider Services Included:	**University Hospitals of Leicester NHS Trust** **Leicestershire Partnership NHS Trust** **George Eliott NHS Trust- Urgent Care Centre**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.

NHS Leicester, Leicestershire and Rutland Cluster - Leicester City	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Good
Contribution of Health agencies to keeping children and young people safe	Good
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Being healthy	Outstanding

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

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

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

The Inspection Process

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

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

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

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

Context:

Commissioning and planning of child and young peoples' health services, including primary care, are undertaken by NHS Leicester, Leicestershire and Rutland Cluster. Universal, targeted and specialist services such as health visiting, school nursing, paediatric therapies, safeguarding, looked after children and community nursing is delivered primarily by Leicestershire Partnership NHS Trust (LPT).

The main provider of all acute hospital services for maternity, children and young people is University Hospitals of Leicester NHS Trust (UHL); this includes an acute assessment and accident and emergency services.

Children and families access primary care services through one of the 64 general practitioner practices, one walk in centre, and/or the urgent treatment centre / minor injury centre, located on the University Hospitals of Leicester NHS Trust Site, which is provided by George Eliot NHS Trust.

Community-based child and adolescent mental health services (CAMHs) and in-patient CAMHs located at Oakham House, are both provided by Leicestershire Partnership NHS Trust.

The lead commissioner for children and young people's health services who has responsibility for all children and maternity provision including jointly commissioned services, and safeguarding is commissioned through the children's, public health and quality teams at NHS Leicester, Leicestershire and Rutland Cluster.

General – leadership and management

1. Health organisations have highly committed and proactive senior managers and executive directors, who are key participants in the safeguarding arrangements across Leicester City. Each health organisation has robust safeguarding governance structures, which were reviewed following the recent changes to the local safeguarding boards (both adult and childrens) within the Leicester City and Leicestershire and Rutland, to maintain appropriate attendance and effective contribution. There is good use made of metrics and other performance measurements and reporting processes such as: the markers of good practice, a range of clinical audits, monitoring of serious case reviews, and individual management review action plans, ensuring sustained changes to practice. All health trusts have concurrent safeguarding policies and procedures with additional operational guidance for some staff groups such as GPs and pharmacists. Good use is made of the looked after children strategic meetings and corporate parenting arrangements, to promote partnership working and improve and maintain the health outcomes for looked after children with improved communication across all partners including representatives from the newly established clinical commissioning groups. New arrangements are currently being implemented to ensure further integration of the urgent care centre service at both strategic and board level, and include representation on the Leicester, Leicestershire and Rutland Health Safeguarding and Well-Being Network.

2. Annual looked after children and the NHS commissioner safeguarding reports are well scrutinised by the local safeguarding children board (LSCB) and the Health and Well-Being Board, with the provider trusts' safeguarding reports presented to their respective trust board, resulting in good levels of challenge and scrutiny.

3. The child death overview panel (CDOP) annual report is effectively scrutinized and challenged by the LSCB members. The urgent care centre staff do not receive any information from CDOP. There are good links between the CDOP priorities and the children and young persons plan priorities, and from strategic guidance, good practice, as well as learning from local and national deaths. This is ensuring that lessons are learnt and that there is continuity throughout the work plans and action plans.

4. There remains a gap in commissioning for the provision of services for children who require support if their parents are substance misusers, which may leave them vulnerable due to a lack of personal resilience building. This is recognised by health commissioners.

Outcome 1 Involving Users

5. Through effective consultation with the Children in Care Council work has recently commenced on a more comprehensive 'health history care leaver information pack'. Care leavers and all looked after young people do have a copy of the 'Clayton File' which contains health education/information and immunisation status, which is shared and discussed at each of their health assessments and reviews. Birth history is also shared, if there has been parental consent. Due to the successful engagement with the Children in Care Council, work on developing dedicated health education materials for looked after children and young people and their carers, including the production of health information leaflets such as smoking cessation and emotional well being is currently progressing.

6. As a result of the multi agency Y-POD project, which focuses on employment opportunities for care leavers, early outcome indicators show that the number of looked after children who are not in education, employment or training is reducing.

7. The child and adolescent mental health services (CAMHs) have recently commenced the You're Welcome quality standards accreditation along with their established service user intervention/evaluation measures to improve service delivery and make services responsive to the needs of children and young people.

8. There has been, through work with parents of children with life limiting conditions forum, the development of resuscitation plans which flag the patient's home address on the police system, to ensure that the wishes of the young person and family are respected when the child dies at home,. The children with disabilities team make good use of the two youth forums 'Big Mouth' which includes fifty young people with disabilities from 5 to19 years of age to review the effectiveness and accessibility of services.

Outcome 2 Consent

9. Consent is obtained before a looked after children health assessment or review is undertaken. Consent is also sought from birth parents when a child or young person comes into care to share birth history and any relevant family health history information.

10. The urgent care centre ensures that appropriate consent is gained prior to any treatment or intervention. Identification of the person with parental responsibility for looked after children and young people was previously not robust, although this has improved since the recent introduction of the SystmOne patient record system.

Outcome 4 Care and welfare of people who use services

11. All initial health assessments are undertaken by paediatric registrars or by the named doctor for looked after children (LAC). The latter also provides highly valued training, supervision and support for the registrars which maintains consistency and adds quality control. Peer review of the health assessments, which includes monitoring that the voice of the child young person has been present in the assessment, is effective with good tracking of cases where this has not been recorded. The looked after children specialist nursing team, who have recently become geographically based, has been very effective in improving partnership working as well as enhancing the engagement with foster carers. These staff undertake all of the review health assessments for looked after children and young people aged five to nineteen years, including the 25% of the most difficult, vulnerable and complex health assessments in this age range, ensuring that the health needs are being identified and met, consequently this has also resulted in high level of engagement from these young people.

12. Initial and review health assessment rates are very good, above England and statistical neighbours, at 93%. Cumulative immunisation rates for all LAC is 83.7%, with some individual immunisation compliance for younger looked after children at 100%. There is very good monitoring of immunisation rates, including those who have refused their immunisation, due to faith or other reasons. Dental assessment rate is 90%, again above both statistical neighbours and England rates. There is good monitoring of health of children placed out of area, with support from CAMH services, if required. There is good access to interpretation services, with a conscious effort made to ensure that the same interpreter is used for the looked after child/unaccompanied asylum seeking children, providing continuity and a trusting relationship.

13. There is a dedicated child and adolescent mental health (CAMH) team and dedicated primary mental health workers for looked after children who are all fully engaged with, and work alongside, the looked after health team. Looked after children specialist nurses make good use of the CAMHs helpline, used to provide advice and support when caring for a young person's mental well being and this helps to ensure that appropriate referrals are made. Referrals are made to CAMHs through the single point of access and referral system, and assessed every two weeks, with fast track routes for those in residential children homes and those who are at high risk of self harming. Assessment appointments are given immediately and therapy sessions usually commence within fourteen days. There are longer waits for specific therapies such as; art therapy, theraplay and some cognitive assessments, although the young person will have ongoing support provided by generic CAMHs.

14. Looked after teenage mothers will be a ‘priority referral’ with the newly established family nurse partnership, using a ‘wrap around approach’ to support the young mother/parents and baby. The family nurse partnership (commenced two months prior to the inspection) has yet to establish a caseload. Specialist looked after children (LAC) nurses provide a ‘clinic in a box’ sexual health services which includes good provision for those young people in residential care settings. Those young women who choose to have a termination of pregnancy are well supported throughout the process, and post termination, ensuring that both their physical and emotional needs are met. When a looked after young woman is known to be pregnant there is good supportive joint care provided by the looked after children specialist nurses and the specialist teenage pregnancy midwives. LAC specialist nurses are provided with additional supervision to both support and enable them to support the young girl especially when the baby also becomes looked after. There has been good use of the ‘reality baby doll’ with looked after young women, to help decision making when a young woman is considering motherhood.

15. The dedicated teenage pregnancy midwives have recently reviewed their guidelines and pathways, resulting in improved clarity for GPs and improved partnerships working with connexions, including good engagement with the service for prospective young parents. All teenage pregnant women and young mothers’ needs are identified and well met through an individualised care package. Joint visiting postnatal (up to twenty eight days) with the dedicated teenage pregnancy midwives and the health visitor provides ongoing good support to the young mothers/parents. Young parents report positive feedback, especially from young fathers, who report that the service recognises them and their needs as individuals. There are established good working relationships with the police and other agencies to meet the needs of those young women who are pregnant as a result of sexual exploitation or to locate and protect from harm Asian young women who have fled from their families. Staff report a low number of concealed pregnancies and when these are identified, a good holistic supportive service is provided. The rate of teenage conceptions, whilst remaining above England and statistical neighbours, is showing a significantly faster rate reduction than England and statistical neighbours, as a result of the range and accessibility of sexual health services and the ethos of providing a ‘wrap around’ supportive service.

16. Effective sexual health services are provided through a range of practitioner based interventions. School nurses support education staff to deliver sexual education within some schools but there remains difficulty in providing provision within some faith schools. Sexual health consultations, sexual health screening and some contraceptives are dispensed from schools, which has improved the contraception and sexual health screening take-up and compliance rates.

17. Health visitors have developed a ‘timetable’ of available sexual health services across the city area, which is distributed to new parents to prevent unwanted second conceptions and has also improved accessibility to services.

18. Choices provide targeted and well accessed sexual health services to young people under twenty-five years of age, providing a good range of contraceptive advice and support to young mothers to prevent unwanted second conceptions. The self referral rate has increased over recent years; with 95% of all referrals now being self referrals. There has also been an increase in the use of long acting reversible contraception (LARC) and good continuing repeat attendance rates at clinics. Clinics are run from a wide range of locations across Leicester City, with over seventy sites now registered as part of the 'safe sex' scheme (condom distribution).

19. School nurses actively promote a range of health 'drop-in' clinics within schools, which focus on universal health needs as well as some targeted interventions based on individual needs; in some faith schools this includes good use of signposting to sexual health services.

Outcome 6 Co-operating with others

20. Changes in placements and new LAC information is not always shared in a timely manner by social care staff, which reduces the time available to complete initial health assessments, although currently these are being achieved within timescale. Further, the strength and difficulties questionnaires (SDQ) scores are not always shared to inform health assessments; however, a new emotional wellbeing tool has been developed to address this identified shortfall. Pilot projects have commenced, but it is too early for evaluation.

21. Service evaluation from young people living in residential children homes shows that the dedicated looked after children specialist nurse role and the focussed residential home based health promotion group work is highly valued and is improving well being and reducing risk taking behaviour.

22. There is good use made of the Strategic Health Authority 'markers of good practice' for safeguarding, which now involve other contracted providers such as the local childrens hospices, NHS Direct, and the private hospitals to ensure that there is a health economy wide approach to safeguarding standards. The markers of good practice for the LAC service have been developed by Leicester City staff and have just been implemented; development is underway for the markers of good practice to be used in GP practices to provide assurance of quality.

23. There is good partnership working between the drug and alcohol services, the Children Rapid Assessment and Follow-up team (CRAFT), and the urgent care centre, with CRAFT providing an effective outreach and follow up service for children, preventing unnecessary admissions to hospital.

24. Generic CAMHs is commissioned to provide kinship care, although these young people are unable to access some of the LAC CAMH service parenting groups due to commissioning restrictions. Generic CAMHs as a result of good partnership working, has effective regular meetings with the local authority children and family team, providing good support to the improve the emotional well being of looked after children and ensuring that these children and young people's treatment is effective. There are well embedded direct self re-referral pathways (through the single point of access) into generic CAMHs for parents of children with learning disabilities and difficulties who have used the service in the last 12 months.

25. There are good networks and partnerships with the CAMHs and young people drug and alcohol services and youth offending teams, providing fast track access to services and support, which includes the residential children homes. There are good links to the 'Freedom club' and fast track access for unaccompanied asylum seeking children who are looked after to CAMH services; with well accessed monthly drop-in and consultation sessions.

26. There is a dedicated mental health and emotional well being provision for young people with moderate and more severe learning disabilities and difficulties who are looked after or in respite provision, however, for those with behavioural problems the provision is less well developed and in some cases there is no service commissioned. Service users' feedback and service evaluations of this dedicated provision is positive.

27. There is a good dedicated 'self harmer' service, which provides a twenty four hour on call service for the accident and emergency department, in line with national guidance. A dedicated school nurse pathway for those young people who self harm provides ongoing support to the young person and advice on management for educational staff.

28. The substance misuse services have made improvements to the referral system, with improved referral pathways and good links to other services such as; sexual health, sexual exploitation services and universal health services. This has resulted in a substantial increase in referrals from schools and a dedicated health education provision supported by the school nursing services to affect change in the cultures of some schools. The service provides targeted provision for those young people assessed to be most vulnerable including looked after children and young people, sexually exploited young people and homeless, as well as young people whose parents are substances misusers and other children in the household who are now using or who are at high risk of using substances. The service provides valued foster carer training and additional support to placements, preventing placement breakdown. These services are easily accessible and several examples were seen of high quality intervention by the children and families support team and CAMHs to maintain placements and avoid placement disruption. There are dedicated and valued substance misuse workers, one working with those young people from south-east Asian countries/origin and the other working with African Caribbean young people, as it has been identified that there is high alcohol and cannabis abuse within these populations.

29. There is good access to tier four (highly specialist) mental health inpatient beds within the Leicester City and Leicestershire. If a young person is placed out of area there is good use made of the care programme approach to ensure that their needs are met, that they are supported during repatriation and provided with effective transition to adult services.

30. The Diana Nurses provide a highly valued service, notably through the education sessions provided to school based staff and staff in residential care/respite care settings, meeting the nursing needs of children disabilities and those with life limiting conditions. Diana Nurses are well engaged in the looked after children/young people health assessments, ensuring that their needs are well identified, addressed and that the assessments are linked to their personal plan and educational reviews.

31. Transition to adult services for children with disabilities has recently been reviewed resulting in clearer pathway planning with education staff. However, there still remain areas were transition pathways are less clear such as for children with behavioural problems, where there is no adult service. CAFs have been used in an attempt to ensure that the young person and family are supported.

32. There is good use by health staff of the 'play zone house' used in conjunction with the local fire brigade, to enable children and young people to identify risks within the house that had previously been identified through analysis of the causes of child deaths.

Outcome 7 Safeguarding

33. The designated and named health professionals provide a good coordinated approach to safeguarding arrangements. There is good use of safeguarding supervision through peer review and case review meetings to ensure that the 'right question is being asked, to get the right answer' resulting in assurance that children and young people are being appropriately safeguarded within all services. Safeguarding supervision is less well developed and embedded in maternity services.

34. Safeguarding referral thresholds are well understood, although community and primary care staff report that there remains some difficulty with emotional neglect and some domestic violence referrals being accepted by social care. These referrals are successfully escalated and discussed at the monthly improvement meetings with social care and the local police to identify and analyse trends and monitor outcomes. Community practitioners report that due to the high rate of domestic violence, the threshold has been raised; leaving some families at potential risk especially if they do not meet the multi agency risk assessment conference (MARAC) criteria/thresholds. However, strategies are put in place to support these families until the referral is accepted. Staff working in the mental health services also report difficulty with getting social care to accept referrals for young people who are transitioning from young people services to adult services or from the youth offending services and that remain vulnerable and at risk of exploitation.

35. The unscheduled care setting (A&Es, urgent care centre, and walk-in centres) notifications are distributed and the dedicated safeguarding team at University Hospitals of Leicester and effectively followed up by the looked after children team, health visitors, school nurses or general practitioners, ensuring that enduring health needs are met. Notification of looked after children's attendance at the urgent care centre are not always sent to the looked after children team, for them to ensure that the health needs identified have been addressed fully. However, there is good monitoring of attendance through the use of SystmOne ensuring that needs are being identified and met.

36. Currently there is only one registered children nurse in the urgent care centre, (another nurse is due to commence shortly), and two GPs with special interest, and although there is good access to consultant paediatric support, this is not always readily available when required. Young carers are not systematically identified in the urgent care centre, although when identified good support is provided. There are good pathways in place from the urgent care centre to the sexual assault referral centre and the genito-urinary medicine centre. Further, there is good access to emergency contraception with confidentiality maintained especially for Asian young women who are concerned about cultural and intergenerational clashes.

37. There is increasing involvement of GPs with safeguarding activities, with 87% of GPs are trained to safeguarding level 3, which is very good and increasing rates of compliance in safeguarding training by other practice based staff. There is good access for GPs to the LSCB website which contains all the safeguarding information and reports templates. GPs are awaiting the pilot of the new case conference report template, which aims to improve the quality and consistently of reports, although they are unclear as to when this is due to commence. GPs willingness to be involved in safeguarding procedures is adversely affected by the slowness in communication and the times of case conferences which frequently are held at the same time as clinic times; concerns and solutions have been raised at LSCB, with no resolution or progress made.

38. There is good use of the Royal College of General Practitioner Safeguarding Toolkit within some practices to monitor the effectiveness of safeguarding arrangements and this has identified a number of staff who have not had a criminal records bureau check. There is good use of 'flagging' alert systems in GP practices, however, recent audits have shown within some practices that the process of removing out of date 'flags' is not robust; remedial action is being undertaken at the time of the inspection. Frequent attendees notifications from unscheduled care settings are reviewed by GPs and early intervention strategies are put in place.

39. Community staff report that frequently social workers are not allocated to cases until after the initial review meeting and before the next conference, resulting in work not being completed in a timely fashion and a lack of clarity as to whom to contact when circumstances change. There is good engagement of community health practitioners at child protection meetings including strategy and case conferences. Community staff that do not have a secure email address find communicating with social care staff more challenging, especially for sharing information about case progression and when receiving feedback on referrals, than those staff working in the children centres who have a secure email address.

40. The common assessment framework (CAF) is effectively used with those families who engage with services, however, those families who will not engage are not always followed up and other interventions are not always used successfully. There is effective information sharing between health visitors and children centre staff, with good use made of the 'Think Family' panels.

41. The health visitor and midwife for the homeless are providing good support for teenage mothers with good partnership working with other agencies to ensure that their needs are met. Those young parents living in hostels and not attending colleges attend the 'parents with prospects' course which has reduced the number of young people who were not in employment or education.

42. Domestic violence incident notices are not always shared with GPs, consequently they are unable to support the families involved. Community staff make good use of SystmOne for the recording of hidden harm, however, there is inconsistency in where information is recorded, resulting in the potential for key information to be missed.

43. The child death overview panel (CDOP) has good representation from partner agencies and, at the time of the inspection, was recruiting lay members. There are good links with the serious case review sub-group including sharing of the overview and summary reports. Monthly meetings are held to review child deaths with annual reports presented to the LSCB. At the time of the inspection there is a countywide review of CDOPs to ensure it is fit for purpose and provides value for money. There have been a number of campaigns to reduce child deaths, audits of information sharing as a result of these campaigns show that parents are aware of the key messages, however, these were not always well communicated to extended family members; plans are in place to address this. There is an effective rapid response team, which includes an on call rota of seven named nurses. The parental evaluation of the care of the next infant (CONI) service is positive. Accident and emergency department (A&E) staff provide a good service to parents when there has been an unexpected death, with good support for staff involved in a child's death.

44. There are effective unborn and pre-birth planning meetings with good partnership working between maternity services and social care. Pre-birth plans are effectively shared between local maternity services and A&E services, with good use of the national alert system as required. The safegaurding specialist midwife is highly valued by staff and provides adequate access to supervision, however, due to limited capacity of the role and only two trained safeguarding supervisors for 300 midwives, and a second, named midwife post is currently vacant, so this limits the capacity of what can be provided. Staff are unaware if the recruitment process has commenced.

45. Baby mapping forms (based on body mapping forms) have recently been introduced for all babies where there are injures noted at birth or as part of the delivery. These forms are shared with A&E and other child health services where a baby (under six months) could be seen or admitted. The baby mapping forms assist with the identification of known 'marks' when undertaking a physical examination, to identify any potential non accidental injuries. The specialist safeguarding midwife also reviews all baby records to ensure that safegaurding concerns are identified; areas of concern are then discussed within supervision, to improve practice.

46. GPs are notified of female genital mutilation (FGM) cases when identified during maternity interventions, ensuring that the women are well supported and education provided to help them with their own children, to prevent further cases. However, there has been no evaluation of effectiveness of this provision.

47. Staff report that there has been an increasing trend in the cases of fabricated and induced illnesses recognised in families where children are alleged to have a disability. Appropriate safeguarding referrals have been made with some success although staff report that this remains a challenge to protect the child/young person from harm despite staff receiving training.

48. There is effective information sharing within and between the children with disabilities professionals and teams. The multi professional referral meeting process ensures that the child and family remain central to decision making. Good use is made of joint visits to maximise service interventions and benefits with minimal distribution for families. The consultant community paediatrician, as part of their annual review for a child with a disability and who is also a looked after child, will complete the LAC annual health review to reduce the need for repeat appointments.

49. There has been effective sharing, through training and newsletters, of the learning from serious cases reviews, with good monitoring of the action plans at the relevant NHS trust safeguarding forum.

<u>Outcome 11 Safety, availability and suitability of equipment</u>

50. The urgent care centre has a dedicated waiting area for children and has the flexibility to use a side room when a more private waiting area is required, or to isolate suspected infectious cases.

51. There is a pooled budget to provide equipment for children with disabilities, based on clinical need, with good use made of equipment recycling.

Outcome 12 Staffing recruitment

52. Through the use of the Royal College of General Practitioner Safeguarding Toolkit in some practices, it has been identified that safer recruitment practices have not been adhered to, with some practice staff not having a criminal records bureau (CRB) check. All other staff interviewed confirmed that they have a current CRB check. There are robust human resources monitoring systems in place to assure NHS trust boards that safer recruitment practices are fully implemented.

Outcome 13 Staffing numbers

53. It is recognised, with most recent government recommendations, that there is over a 40% shortfall in health visitors and well developed strategies are in place to train and recruit further staff. School nursing service reports a vacancy freeze which is starting to impact on the service's capacity. There has been some engagement from health with partner agencies in developing joint strategic workforce planning.

Outcome 14 Staffing support

54. Looked after children dedicated staff have good access to highly valued training based on training needs analysis and service needs. Designated LAC staff are currently attending the strategic health authority (SHA) leadership programme to enhance further their leadership skills. All designated staff have good access to supervision, with good use of regional networks providing additional support and supervision. There is a very proactive and dedicated LAC designated nurse and specialist nursing team; championing and advocating on behalf of looked after children and young people.

55. All named staff have access to supervision and specific training based on their needs. All health staff interviewed confirmed that they have good access to safeguarding training, including thematic training, although most level three training attended by staff is single agency, which misses the opportunity of improved understanding of other agencies and improve partnership working. All community health and acute health staff have good access to safeguarding supervision.

56. Urgent care centre staff have received training in children pain assessment and paediatric life support, and are up to date with their safeguarding training. Safeguarding training at Leicestershire Partnership Trust overall compliance rate is 83.7%; however, level 2 compliance is only 76%, with a strategy in place to increase the rate of compliance. University Hospitals of Leicester total safeguarding training compliance is 84%, there is good compliance by Leicester City healthcare staff at 93%. There has been some measurement of the impact of training on practice through the ongoing audits, although recommendations are still to be fully embedded.

Outcome 16 Audit and monitoring

57. There is strong partnership working and cognisance being given being paid to the cultural needs of looked after children, which is subject to rigorous audit to ensure that any needs are fully addressed. There is good support, shown through regular audits, for looked after children who have been subject to sexual exploitation with good partnerships working with other professionals. There is good monitoring of the sharing of a looked after child health information on SystmOne informing their education needs assessment and enabling looked after children to be well supported in schools.

58. Good use is made of the outcomes from the Section 11 safeguarding audits, showing good levels of compliance with regularly monitored action plans through individual NHS trust governance structures.

Outcome 20 Notification of other incidents

59. Staff are aware of procedures to raise concerns and address allegations against staff members, although those interviewed had not needed to use them.

Outcome 21 Records

60. All LAC health records seen complied with statutory guidance and professional guidance and showed some exceptional work with the most vulnerable looked after young people especially those who have been sexually exploited. The British Adoption and Fostering Form (BAFF) is being reviewed to ensure that the assessment framework continues to be fit for purpose and meets the needs of the local looked after population.

Recommendations

Those recommendations in italics are shared with the joint report with Ofsted.

Within 3 months

NHS Leicester, Leicestershire and Rutland must ensure that there is timely access to and a sustained skill mix of specialist children expertise when a child or young person is in the Urgent Care Centre.

NHS Leicester, Leicestershire and Rutland must ensure that children with behavioural difficulties are enabled to access emotional well being services and supported through transitions to adult services.

NHS Leicester, Leicestershire and Rutland to ensure that children and young people placed in kinship care are not disadvantaged in accessing mental health and emotional well being treatment services.

NHS Leicester, Leicestershire and Rutland must ensure that maternity service capacity for safeguarding supervision, matches the identified need.

NHS Leicester, Leicestershire and Rutland must ensure that independent contractors comply with safer recruitment procedures as stated in their service contracts.

NHS Leicester, Leicestershire and Rutland and Leicester City council must ensure that where families fail to engage in the CAF process that alternative interventions are put in place to protect the children and young people from harm.

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.