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

Date of Inspection	**23rd April 2012 – 4th May 2012**
Date of final Report	**13th June 2012**
Commissioning PCT	**NHS Southampton**
CQC Inspector name	**Jacqueline Corbett**
Provider Services Included:	**Solent NHS Trust** **University Hospital Southampton Foundation Trust**
CQC Region	**South (Central)**
CQC Deputy Director	**Ian Biggs**

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 .

Southampton County 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	Adequate
Being Healthy	Good

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

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's 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:

Commissioning and planning of national health services and primary care are carried out by NHS Southampton as part of the Southampton, Hampshire, Isle of Wight & Portsmouth Primary Care Trust cluster. The Southampton Clinical Commissioning Group, due for authorisation prior to 1st April 2013, currently operates within NHS Southampton.

Children and families access primary care services through one of 38 GP Practices, with a walk in centre and a minor injury unit which are both provided by Solent NHS Trust. Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by Solent NHS Trust, who are also the primary providers of community-based services for child and adolescent mental health services (CAMHs). There are partnership arrangements in place with the Local Authority for specific areas of provision, including Tier 3 CAMHS and the Behaviour Resource Service (BRS) which is an integrated specialist health, social care and education provision for children, young people and their families who have severe and complex emotional and behavioural difficulties.

Services for children with learning disabilities and difficulties and who have complex health needs are provided by Solent NHS Trust with partnership arrangements for specific areas of provision, in particular the “Jigsaw” integrated health and social care service and the intensive intervention support team for children and young people with severely challenging behaviour.

The acute hospital providing Accident and Emergency services for children is University Hospital Southampton Foundation Trust. Maternity and newborn services are also provided by University Hospital Southampton Foundation Trust.

General – leadership and management

1. Health partners in Southampton contribute effectively to the strategic planning and commissioning of children and young people's health services. Collaborative commissioning across health, social care and other partners has led to a number of effective jointly commissioned services, such as the Behaviour Resource Service (an integrated team supporting children and young people with complex emotional or behavioural difficulties); and the Family Nurse Partnership (which provides intensive support to teenage parents).

2. A recently refreshed joint strategic needs assessment highlighted health needs in Southampton linked to increasing birth rates, high levels of deprivation and increasing numbers of children in need and being looked after. This has informed priority setting and planning across health and social care partnerships, for example in effective action to reduce comparatively high levels of teenage pregnancy in the area through the implementation of a joint strategic plan.

3. Health commissioners have also been actively involved in a number of recent service reviews, and have demonstrated an effective response to addressing service development needs across the range of provision for children and young people. For example, additional resources have been made available for health visiting, midwifery and hospital based safeguarding teams which has had a positive impact on improving capacity to meet local health needs.

4. The Child Death Overview Panel (CDOP) provides an effective mechanism for identifying systemic causes of infant mortality in Southampton. This usefully links with panels across the health cluster area of Southampton, Hampshire, the Isle of Wight and Portsmouth (SHIP) to provide a wider data base for analysis and comparison of trends. This has led to targeted action such as promoting safer sleeping arrangements.

5. The LSCB meets its statutory responsibilities and provides effective leadership in relation to safeguarding across the spectrum of provision. Well-defined governance arrangements ensure regular communication between the LSCB and the Children's Trust, with clear respective roles and accountabilities. The LSCB chair is highly experienced and provides appropriate and effective challenge to the partners.

6. There is good representation from health partners on the Board and its sub-committees, which are increasingly rigorous in overseeing the quality of safeguarding systems and practice across provider services. Priority has been given to addressing deficits identified in some practice areas following serious case reviews (SCRs), although the reports and action plans from these incidents had not been finalised at the time of this inspection. The SCR sub-group of the LSCB disseminates the lessons learned from serious incidents to all agencies, and is effective in driving improvements through close monitoring of action plans. Health commissioners are working closely with providers to address identified areas for development, for example in securing improvements in systems for information sharing across front line practitioners and in multi-agency assessment of risk. However, the wide range of work being done is at early stages and needs to be embedded across teams and services.

7. Safeguarding specifications have been reviewed and strengthened in all commissioning contracts, and compliance is monitored by the commissioning team through quarterly reviews with providers and performance monitoring. A performance dashboard is being developed but is not available yet.

8. Good governance structures are in place to ensure that provider health trust boards have sufficient oversight of their arrangements to safeguard children, and there are clear reporting lines to the LCSB. Self-assessment audits of provider trusts (Section 11 audits) are closely monitored to ensure targets for improvement are complied with. These audits indicate high levels of compliance with safeguarding requirements across providers.

9. Solent NHS Trust was created as a stand alone organisation on 1 April 2010 following the reconfiguration of the NHS Southampton and NHS Portsmouth PCTs and brings together community and mental health services across Southampton and Portsmouth. The Trust has worked to establish performance monitoring systems and reporting lines to commissioners over a period of significant change to ensure effective evaluation of its services. It is too early yet to determine the impact of the changes or measure the delivery of the efficiencies intended to be gained by the Trust through the internal restructuring underway at the time of the inspection.

10. The designated doctor and designated nurse for safeguarding posts were located within Solent NHS Trust and have only recently been moved into the PCT, NHS Southampton in line with statutory guidance "*Working Together to Safeguard Children*". A lead for safeguarding for GPs is contracted in to provide training and oversee strategic arrangements across Southampton GPs. The post-holders have strategic oversight of the implementation of action plans relating to the recent serious case reviews (SCRs), and are part of the SCR sub-committee. Priority is given to ensuring that there is effective improvement in identification of and response to safeguarding concerns across provider services, which is being achieved through an increased focus on performance monitoring and supervision with named nurses.

11. The designated doctor and nurse for children looked after posts are located within the provider trust, Solent NHS Trust. The post holders have clear oversight of the operational responsibilities of the children looked after team. However, the strategic aspects of the role are underdeveloped, and it is unclear how responsibilities for strategic planning and reporting to the PCT are undertaken. For example, the designated nurse contributed to a joint annual report, "Safeguarding children and young people", which incorporates reporting on the health of children in care, but insufficient prominence is given in this to analysis of the service provided to children looked after, and there is no strategic review or impact.

12 The corporate parenting group has good membership which includes health, social care and other partner agencies such as housing. This group has appropriate information provided which enables it to identify key issues for children in care. There is evidence of effective challenge within the group and officers being held to account for the quality of care that children looked after receive.

Outcome 1 Involving Users

13. The contribution from children and young people in respect of giving feedback on the individual service that they had received was being developed across the range of health services. For example, the children looked after health team have recently acquired "i-pad" style equipment for young people to be able to give feedback electronically and in private, which is good. There is also a well-established and effective Young Inspectors programme to evaluate the quality of services on a wider level. Their inspection programme has recently included a number of health services including CAMHS and BRS. The Young Inspectors produce reports with judgements on the quality of the service and the involvement of young people. The service provides a response with an action plan of how it will make improvements, for example in making adjustments to the physical environment, accessibility or information provided.

14. Service user consultation is being increasingly undertaken in service planning and development, such as the commissioning review of services for children with disabilities, and more recently in relation to the planned recomissioning of drug and alcohol services for 11-24 year olds. Positively, care leavers had been involved in the selection of staff for the Looked After Children's health team, and they reported that they felt that they had had a meaningful impact on the recruitment process.

15. The children in care council meets regularly however currently there are only a very small number of children in the group and this limits its impact and ability to represent the views of the large population of children looked after. Work is being undertaken to improve their involvement through promoting networking in schools, co-ordinated by a participation worker. Young people have influenced the development of a facebook page where young people looked after can communicate with each other. During the inspection, the council facilitated a large group of children looked after to meet with inspectors. Those who participated indicated that they would like to meet together as a group more often, and this is being considered by the council and its partners.

16. There is good participation of children and young people in their health reviews, and their views and opinions were highlighted in the health assessments seen during the inspection. Children who are looked after are supported to contribute to decisions about their lives with appropriate translation and advocacy services provided to help them express their views and participate in their reviews. The diverse needs of children with a disability are robustly assessed and considered within the work of the Jigsaw team. There are some services that address issues of diversity for children and young people, including "Breakout", a support project for young people aged 13 to 21 who identify as lesbian, gay, bisexual, transsexual, transgender or who are unsure of their gender or sexual identity.

Outcome 2 Consent

17 There are appropriate policies and procedures in place for staff to ensure that parental or carer consent for treatment is obtained prior to any treatment of children and young people. The Gillick competency of young people is fully assessed within all services but particularly within sexual health. Accident and Emergency staff routinely establish who has parental responsibility for the child and therefore who can consent to treatment.

Outcome 4 Care and welfare of people who use services

18. Health services in Southampton are being developed to more effectively promote positive health outcomes for children and young people, with additional resources being made available to ensure capacity to meet a rapidly increasing level of demand due to increasing births and the more complex health needs of the population. There are some good quality and highly valued services, and evidence of improvements across a wide range of health provision. Where commissioning and provider agencies identify areas for improvement, effective action is taken. However, work remains to be done to embed consistency of quality across all health services and to ensure that a comprehensive service is in place that meets continuing growth in local needs.

19. The midwifery service has a track record of improving health outcomes for mothers and babies in Southampton, with steadily decreasing rates of mothers smoking, an increase in breast-feeding, and a decline in low birth weight babies and infant mortality rates. The midwifery service offers different models of care, one of which is a case loading model focusing services on areas of deprivation in the city to reduce health inequalities. The service has a dedicated team of practitioners who work with young mothers (YPMP), and in recent years the support to young parents has been strengthened by the development of the jointly funded Family Nurse Partnership (FNP). The FNP offer intensive support, parental training and care planning for all young people who will be under 18 at the birth of the child, or aged up to 20 where the young person has been in care. This service is highly valued by those that use it and by partner agencies working with the young people concerned, and it has had an impact in improving health outcomes for them.

20. Recent action has been taken to improve staffing levels and address increasing case load allocations across the health visiting and school nurse teams, as capacity pressures were undermining effective work and quality of practice including joint working across the teams. A service review of the school nurse service has led to a clearer focus and prioritisation of key milestones and transition points. The health visiting service has been expanded to enable better case load management, mapped to the trajectory of expected births. Although health practitioners and managers were positive about action taken, it will take some time to achieve target recruitment levels to ease pressures on capacity and support optimum effective working. It was too early to be able to evidence impact on practice and outcomes, or to determine whether any improvements are sustainable.

21. The children looked after health team is small, and a post was unfilled at the time of this inspection as the post holder had recently gone on secondment. The staffing establishment has not changed despite a significant increase in the number of children entering care, which had risen from 376 in 2009/10 to 571 in 2011/12. This has had an impact on the capacity of the team to maintain the high and improving performance in undertaking health assessments achieved in previous years. Performance in undertaking health assessments of children new into care has been sustained at 88%, but performance in undertaking health and dental checks across all children looked after fell from 92% to 81% (although this remains in line with comparators). In recognition of the increasing demand for the service, a commissioning review of the service is planned.

22. Initial health assessments of children looked after are undertaken by the team's paediatric doctors to promote consistency in practice and quality. Health assessments are undertaken at a local venue, No Limits, which is conveniently located and de-stigmatises attendance for children and young people as it is a centre for a range of services. However, some young people told us that they were not offered a choice of venue. Health assessments seen were thorough and child focused, and considered wider social concerns that could impact on the young person's health such as housing and support.

23. Health outcomes for children looked after generally were good. Health care plans reflected the issues identified in the assessment and were regularly updated. The care plan as well as a summary of the health assessment is copied to other agencies involved in the care of the child, and sent to the children looked after review in order to ensure good information sharing. Practitioners across the range of health services reported that they are well engaged in relevant aspects of undertaking the action points in health care plans.

24. The children looked after team undertake the health assessments for the majority of children in care who are placed outside of the area, as most are within 20 miles of Southampton. This promotes continuity of care and ensures that the team are aware of progress and health outcomes across all children and young people in the care of Southampton City Council.

25. The children looked after team work with the social care team, Pathways, which acts as the lead agency in developing and overseeing care planning for young people leaving care. The children looked after health professionals contribute to this appropriately, providing young people with personal health summaries and signposting to adult health services. As the children looked after clinic is based at No Limits, this enables young people who have left care to have contact with the team, although this is on an informal basis and there are no specific protocols for providing support to care leavers. However, care planning in the Pathways team was found to be of an inconsistent quality in this inspection, and there was evidence of insufficient planning and support to some vulnerable young people who are placed in hostels upon leaving care. Young people who had this experience told us that they felt that they did not receive adequate preparation and emotional support for independence. A more proactive approach to supporting young people who have left care would support better health planning for them.

26. Community dental services in Southampton have been expanded following a refreshed needs assessment, in order to address identified barriers to access through extended operating hours, increased drop-in appointments, improved accessibility to vulnerable groups and increased home visits including to care homes. A dental care pathway and prevention strategy are being developed, and a pilot intensive oral health programme is about to be launched to screen all 3 to 5 year old children and promote dental hygiene.

27. Children and young people including those looked after have good access to comprehensive contraception and sexual health (CASH) services. CASH services were reconfigured in 2008 to provide two community based clinics that are more accessible to young people, and a better co-ordinated service that provides a more prompt response to people using the service including access to termination services. Dedicated outreach workers provide education and 1:1 sessions with young people around sexual health and relationships across schools and in conjunction with other agencies such as No Limits and the youth offending team. The “Girl Talk, Boy Talk” provides single-sex educational sessions, including targeted work with young fathers aimed at reducing serial parenting. A specialist worker for the children of parents who are HIV+ has had a positive impact on health outcomes for that cohort. Rates of teenage pregnancy in Southampton are higher than comparator groups, but have shown a steady decrease in recent years, and rates of pregnancy among children looked after are low. A specialist safeguarding children nurse for sexual health and learning disabilities has developed a risk assessment tool for underage sexual activity which supports practitioners to assess the vulnerabilities of young people with learning disabilities engaging in sexual relationships. The Family Nurse Partnership team work closely with sexual health team, including undertaking joint visits and making referrals to promote health outcomes including reduction in subsequent births.

28. The number of local foster placements available for both young mothers and their babies has been increased, and there are seven supported flats available for young people up to the age of 24 with their babies. Parenting assessments are undertaken at local children’s centres and there are a number of services to support young parents including fathers in “Daddy Cool” sessions.

29. There are some highly valued and effective services to support the emotional well-being of children and young people in Southampton. Since 2009, the CAMHS service has provided a training and support programme for staff in other agencies who work with children and young people, to promote awareness of the signs and symptoms of mental health problems and to develop those practitioners’ skills in identifying and responding appropriately to them. This has been evaluated over three years and is viewed very positively by those that attend the course. There are also a number of independent sector services providing counselling and support to young people and families, such as “Steps to Care” (a counselling service for parents) and No Limits (a multi-agency service for young people that includes counselling).

30. In addition, the jointly funded Behaviour Resource Service is provided to children aged between 5 and 18 years old, and their families and carers. It aims to support emotional well-being and prevent placement breakdown primarily for children looked after or those subject to child protection procedures. The service is extremely well regarded by referring agencies, and demonstrates a significant improvement in emotional well-being for the young people that use its services through evaluation using Strengths and Difficulties questionnaires. A local authority service, the Adolescent Resource Centre (ARC), offers respite care for teenagers and intensive work with families to prevent young people entering the care system where this is appropriate. Although the impact of the work is too early too assess, evidence from some individual cases is positive.

31. However, concerns have been identified across a range of stakeholders about the availability, co-ordination and effectiveness of early intervention, prevention and emotional support service for children and young people in Southampton, following the recomissioning of key services in 2011. A change in service delivery and referral arrangements was implemented for CAMHS following a service review and public consultation in 2010. This was prompted by a multi-agency triage and short-term intervention service, “Saucepans”, no longer being provided and therefore there was a need to refocus health CAMHS workers within the resources available. The threshold for access to CAMHS was raised, although the service specification for the community CAMHS teams was amended to include a role for staff to support and supervise staff in other agencies who were working with children and young people who have emotional or mental health problems that do not meet the threshold for CAMHS, and to signpost people to other appropriate services. This triage was intended to work in conjunction with a newly established multi-agency CAF (common assessment framework) panel to ensure that all young people had good access to the most appropriate service for them. The impact of these changes on health outcomes for children and their families has not yet been fully evaluated. As there is currently no system being used to evaluate the emotional well-being of children and young people in Southampton generally, there is a gap in the analysis of whether the services that are available are sufficient to meet local needs, particularly for young people who need more than low-level intervention such as counselling. The range and adequacy of the provision is being reviewed by the local safeguarding children’s board (LSCB) as well as by Solent NHS Trust, in response to the concerns raised by stakeholders, in order to map provision and review accessibility. .

32. There are two community based services for CAMHS – the Orchard Centre team works with children up to the age of 14, and the Brookvale team work with young people aged 14 – 18. Access to initial assessments for CAMHS services across both teams is prompt, with an open referral system. Referrals for treatment are then reviewed in the Therapeutic Panel to determine priority. CAMHS provides an effective service to children and young people who access it, although there can be long waiting times for specialist services such as CBT and clinical psychology. The CAMHS team provide intensive support to young people in the community to ensure that they are diverted from in-patient admissions wherever possible. Tier 4 (in-patient) services are commissioned through the adult mental health provider, Southern Health, at a specialist adolescent unit in Winchester, Leigh House. Difficulties in accessing beds at Leigh House on an emergency basis have been acknowledged by health commissioners and action is being taken to address this by increasing capacity in the service, although this is as yet at business plan stage. Private sector beds are utilised when the need arises in the interim.

33. Children and young people have good access to substance misuse services in Southampton. DASH (Drugs Alcohol Support Health) is a joint health and independent sector service for young people. The service has a high rate of young people completing programmes and in promoting good outcomes from treatment. Children and young people who are looked after are screened for drug and alcohol misuse, and the children looked after nurse has been trained to offer advice and support where there are concerns about substance misuse. Referrals of children looked after to substance misuse services are increasing, but rates of referral from this group remain lower than comparator groups. The causal factors for this are being explored.

34. Children and young people with physical or learning disabilities who have complex needs have good access to assessment and treatment services through the integrated health and social care teams at Wordsworth House and JIGSAW. The teams provide a consistently high quality of service, and are highly valued by users, carers and professionals working with the young people involved. A new, integrated health and social care Children's and Young Person's Development Service is being developed from these current joint services, which will extend the age range of service users up to 25 years of age and streamline care pathways, including transition into adult services. The first stages of this integration were due to start at the time of the inspection.

35. For children and young people who do not meet the threshold for JIGSAW, there is prompt access to initial assessments for therapy services including occupational health and physiotherapy, although there are high eligibility criteria and significant waiting lists for some services such as speech and language therapy (SALT). Health commissioners had undertaken a review of SALT services and a reconfiguration of the teams was underway that was intended to promote early intervention and increase capacity. However, this was too recent to be able to evaluate its impact. The community children's nursing team offer care and support for children and young people at home with nursing needs, in order to promote early discharge from hospital and decrease re-admission rates. The team were leading a pilot service in Southampton, COAST (Children's Outreach Assessment and Support Team) to promote hospital diversion for children with common paediatric minor illnesses that can be managed at home, eg. Gastroenteritis, croup, tonsillitis, bronchiolitis and other respiratory conditions. It was too early to assess the impact of the service, but early feedback was positive.

36. There were insufficient services to meet the increasing number of children and young people with autistic spectrum disorders at the time of the inspection. However, a small pilot to support parents had recently been undertaken and was being evaluated, and health commissioners are developing an autism support service, which was at the point of going out to tender.

Outcome 6 Co-operating with others

37. Systems to ensure that there is appropriate information sharing and joint work across health teams and with other agencies are being strengthened following weaknesses identified in recent SCRs. There is evidence that this is having a positive impact in co-ordinating health care across the range of services, although progress varies across teams and sectors.

38. There is good contact and liaison with hospital maternity services, midwifery teams, health visitors and the FNP, with regular meetings and joint ante-natal visits between practitioners to ensure the early identification of health concerns and well-coordinated health care from before the birth through to post-natal care. Health visitors and school nurses are now all accessing the same electronic recording systems, RIO, which practitioners identified as being helpful in sharing information and improving communication.

39. Services provided by children's centres are effective in making contact with the families of new born, planning support and helping families develop their parenting skills. This is well co-ordinated in centres where health visiting staff are co-located in children's centres, although practitioners reported some challenges in communication where this was not the case.

40. There are specialist posts to provide focused health intervention in liaison with other agencies across different health teams. This includes a health visitor who works with mental health professionals and the housing department to support homeless people, and another who works with Sure Start to create links with the traveller community in Southampton. Specialist midwifery leads have dedicated time to support colleagues, provide training and advice, and take responsibility for multi-agency liaison in specific areas including mental health, substance misuse, and domestic violence. A hospital based liaison health visitor ensures that relevant health professionals are notified about the attendance of children and young people at hospital, and of any relevant concerns which may require early intervention and preventative work but which fall short of child protection.

41. Health practitioners are increasingly undertaking CAF assessments – a recent audit identified that a quarter of all CAFs were completed by health based staff. However, communication, information sharing and joint working across health and social care were consistently identified by health practitioners as a continuing source of concern. The CAMHS and BRS teams include social workers who enable a more joined up approach across health and social care services, which is valued across the services. Action has been taken to establish links and joint health and social care meetings across other teams, for example, health visitors attending social care team meetings to discuss cases. Joint protocols have been developed, for example Southampton's safeguarding protocol for undertaking section 47 enquiries (reports of concerns about a young person) includes health staff, and a joint care pathway for the FNP has been established. However, challenges persist as health practitioners report that the high turnover of staff across social care teams continues to undermine establishing effective working relationships and consistency of response from social care teams. Southampton City Council is aware of the impact that difficulties in recruitment and retention of its staff has had and is working to stabilise the workforce.

42. The quality and effectiveness of transition planning for young people moving into adult services was generally good. For young people with disabilities who were in contact with JIGSAW, transition planning to adult services started at age 14, and was effective in securing multi-agency work to ensure a positive transition and secure appropriate services. Early transitions planning for other children and young people with a disability is supported by an occupational therapy transitions team, and a transition community nurse. However, there were areas where transition planning was sometimes inadequate and therefore impacted on the ability to secure a positive outcome for the young people involved. Staff working with young people with some physical disabilities reported difficulties in identifying and accessing appropriate adult services. In some service areas, for example for young people with some physical disabilities and those with mental health problems, health practitioners reported difficulties in securing effective engagement of adult services for planning transitions at an early stage. There were some gaps in service provision for young people who left specialist schools at age 16 until they could access adult services at 18, which is a significant gap for those concerned. CAMHS practitioners at Brookvale continue to work with young people after 18 and prioritise redirecting young adults to alternative services in the community in order to promote better outcomes for them.

43. Practitioners across health teams as well as the looked after children's health team commented positively on access to the services provided by the DASH team for young people with substance misuse problems. DASH practitioners promote good working relationships and information sharing through maintaining good communication with other health teams, including attending meetings with CAMHS and links to hospital paediatric services. DASH works with children and young people up to age 19, with drop-in sessions available for those up to age 25. This extended age range enables the service to support young people to access appropriate adult services if they need it. However, a service review noted that the rate of transition to adult substance misuse services was low, with indications of poor outcomes for the young people concerned later in life. That is, many would re-present to adult services at a later stage, but with more significant substance misuse problems. Consequently a new substance misuse transition service for children and young people aged 11 – 25 years is being commissioned to be provided from April 2013.

44. Internal management reviews following two recent SCRs identified significant deficits in the arrangements for the identification of 'hidden harm' and in information sharing and joint working around this. That is, practitioners working with adults were not identifying or responding to factors in the health, lifestyle or circumstances of the adult that may present risks to children that they have contact with. While training had been carried out in adult mental health and substance misuse teams around the "Think Family" approach, this was not embedded and there was a lack of effective communication systems. A social worker based in the adult substance misuse team has a lead role in supporting and advising colleagues who work with adults whose children are known to social services, and has links to the social care teams. However, maintaining communication had been challenged by turnover in social care teams and capacity was limited to ensure robust communication in all cases. The SCRs had triggered a renewed commitment and focus to address this area, and protocols and systems were under review. A new task and finish group had been established to develop a system to identify and respond to the most high risk families where there is history of domestic violence, substance misuse and mental health problems which may impact on the health and well-being of the children. This includes plans to undertake an audit of all cases, mapping pathways across adult mental health and substance misuse services and children and young people services. However, this is at the earliest stage and has yet to have an impact on practice or service delivery.

45. Prompt action was taken by the safeguarding team at University Hospital Southampton to address issues identified in the SCRs that related to identifying risks to children and young people when adults attend the Emergency Department. Focused training and a new protocol for raising concerns has led to a significant increase in concerns being identified and responded to, which had led to positive outcomes in safeguarding children and young people.

46. All health practitioners reported positive working relationships with the police. At operational levels, effective arrangements are in place to enable close collaboration and communication with the police child abuse investigation team. Multi-agency Public Protection Arrangements and the Multi-Agency Risk Assessment Conference arrangements are well established, with appropriate protocols and representation from relevant agencies at suitable strategic and operational levels. A joint protocol across health and police teams for the rapid response to sudden, unexpected child deaths has been established, co-ordinated by the liaison health visitor based at the Southampton General Hospital, with support from the designated doctor for safeguarding. This enables a prompt joint home visit between health and police staff to take place to assess the situation and determine if child protection or serious case review procedures are necessary.

Outcome 7 Safeguarding

47. Two recent internal management reviews undertaken in response to SCRs identified significant deficits in the effectiveness of systems and practice for identifying and responding to child protection risks across health providers in Southampton. Health commissioners and providers have responded to this with a renewed focus on prioritising safeguarding children and young people, and taking wide-ranging action to make improvements across the health economy.

48. NHS Southampton PCT working with providers has taken action in a number of areas to improve identification of risk, early intervention and collaborative working across teams and partner agencies. Information sharing and joint working across health visitors, social workers and GPs has been strengthened through new protocols, revised notification forms and establishing multi-agency meetings. A pilot of monthly meetings between GPs, health visitors and social workers is underway, to enable practitioners to share information about any child protection concerns that they have, and determine a joint response. Another pilot project is planned that links an advocacy worker to GP surgeries to identify and work with people at risk of domestic violence, known as IRIS (Identification and Referral to Improve Safety). A number of new risk assessment and information sharing systems have been introduced, with intensive staff training in areas such as the Family Health Assessment Tool for health visitors, and a “tool-kit” with new templates for GPs to assess and report safeguarding concerns about children and young people. Training around a new “Was Not Brought” protocol has raised the profile of situations where children and young people do not attend health or dental appointments as an indicator of potential wider problems. These initiatives are being positively received by the practitioners involved and there is evidence of increased identification of risk factors, but work is at early stages and has yet to be evaluated and embedded across teams and services.

49. All of the children looked after health practitioners are located within the wider Solent NHS Trust health safeguarding service, and the designated CLA doctor is also the named doctor for safeguarding. This promotes good information sharing and joint working where there are safeguarding issues relevant to the children and young people in contact with the children looked after team and vice versa.

50. An ante-natal screening tool for use across midwifery teams, health visiting and social workers had recently been implemented to promote risk assessment and information sharing across teams. This is intended to identify any risk factors in the wider social environment including gathering relevant information about the extended family, and an early audit had identified that this was effective in increasing identification of risk factors by health and social care staff. In addition, a project was about to be launched to bring health and social care managers together in a "buddying" system, with externally facilitated training, to promote joint working and consistency in identifying thresholds for concerns.

51. Specialist midwifery posts promote co-ordinated working in planning the peri-natal care of women who are pregnant who are also vulnerable due to substance misuse, mental health problems or domestic violence. Midwives with these lead roles support and advise colleagues to ensure that there is adequate risk assessment and liaison with social care teams to secure robust pre-birth planning. Joint working across the YPMP and FNP has brought about more effective pre-birth planning for teenage mothers, enabling a more intensive package of support to promote positive outcomes for the mother and baby. There is good pathway planning across community midwifery teams and hospital based maternity services. An effective system is in place to screen all children and young people accessing the Emergency Department at University Hospital Southampton to determine if they are subject to child protection procedures in either Southampton or Hampshire. This is 'flagged' electronically on their health records so that practitioners are alert to any signs or symptoms that may be of concern.

52. All children's attendances at hospital are identified and notifications made to GPs, health visitors and school nurses which promotes identification of risk and continuity of care. No child is discharged without sign off by an appropriately experienced doctor. There are good links between Emergency Department and paediatric in-patient wards to ensure that children and young people are assessed and admitted appropriately. The co-location of a CAMHS teams at the hospital ensures timely access to assessment for children and young people who self-harm, and there is a policy that all young people under 14 years old who are intoxicated are admitted, which promotes comprehensive screening for child protection concerns. Staff demonstrated a good awareness of the need to identify underlying substance misuse factors when assessing young people attending the emergency department. A new protocol is being developed so that young people who are intoxicated will have to "opt out" of a referral to the DASH team rather than "opting in". That is, they will be automatically referred to the team unless they specifically object. A one-year pilot is also being launched to identify and support frequent attenders to the paediatric Emergency Department. A team of staff will identify repeat attendances and audit trends in order to clarify and review care pathways. This will be evaluated to inform service development in 2013.

53. There are robust systems on the paediatric wards for the assessment of children and their parents and carers to screen for issues of concern such as domestic violence. All staff reported that they had had training on asking "difficult questions" and felt confident in doing so. This was supported by a new self-completion form that covered similar areas, which staff reported helped ease the introduction of discussion of such topics. An audit is done of all assessments of young people who self-harm to ensure that questions are asked about domestic violence, abuse or substance misuse. Where there are concerns about any young person admitted to the ward, a multi-disciplinary assessment is undertaken before they are discharged to ensure that all practitioners involved are satisfied that the discharge is safe and appropriate. This is good practice.

54. Emergency Department staff complete Concern Forms daily for Children's Social Care and copy them to the hospital Liaison Health Visitor, for concerns which fall short of child protection but which may require early intervention and prevention. The Liaison Health Visitor screens forms to ensure that they are appropriately completed, gives feedback to individual staff, and follows up any issues through liaison with safeguarding teams and other health professionals. The Liaison Health Visitor also gives monthly feedback on trends in reporting to team leaders, and produces an annual report. Practitioners were very positive about the use of the forms and could identify many examples of where this had led to effective early intervention to protect young people. Following an intense programme of safeguarding training, the number of completed Concern Forms has risen significantly, and the capacity of the post-holder to maintain this role is stretched. All cases of actual or suspected child abuse or neglect are immediately referred to the UHS specialist health Child Protection Team on site or to Children's Social Care Emergency Duty Team if out of hours.

55. Solent NHS Trust provides facilities for the medical examination of children and young people who are victims of sexual assault or abuse including a specialist centre based at University Hospital, the Magnolia Centre. Specialist forensic examination is provided by community paediatric consultants from Solent NHS Trust. The service is highly regarded and valued, but there is not provision at weekends for children under 13 years, which significantly undermines good care and outcomes when the need arises, although level of demand is low.

56. Health professionals working with children and young people demonstrate a good understanding of child protection across all teams, but they report that they experience difficulties in contacting and achieving a consistent response from social work teams when making referrals to them. Most practitioners felt that thresholds were high and inconsistently applied, and that they needed to be persistent and to escalate concerns to get a response. Most felt that there had been an improvement recently, although there were differences in the extent of this. Particular difficulties arise in communication with social care teams that have a high turnover of staff.

57. Although health practitioners are increasingly well engaged in child protection procedures including attending meetings, this needs to be improved and embedded. Practitioners across a range of health teams reported that they do not always get notification of case conferences, or insufficient notice to be able to attend. A new protocol has been introduced for GPs to be able to submit a report if they cannot attend meetings and this has helped promote information sharing although it needs to be more widely used and embedded in practice.

58. A new protocol has been established for the multi-agency review of all alerts generated by the police when they are called out to situations where children and young people are present and are concerned about risk. This promotes early identification of risk and has triggered early medical assessments. However, it is at early stages and is due to be evaluated in six months' time.

59. Across all health services, work is being done to improve joint working with adult services such as adult mental health and substance misuse services, to ensure that there is early identification of risks to children and good information sharing to enable prompt intervention. Effective links have been established, although it is recognised that this is at an early stage, and needs to be embedded and extended.

Outcome 11 Safety, availability and suitability of equipment

60. While the physical environment at the Emergency department at University Hospital Southampton is generally compliant with recent national standards for the physical environment (RCPCH 2012), it is inadequate to meet the specific needs of children and young people using the service. There is a separate Emergency Department entrance for people aged 18 and under, although the waiting area is sparsely furnished, with hard chairs and little provision for occupying young people while they are waiting to be seen. At the time of this inspection, two of the toilet facilities were out of order. Staff reported that efforts are made to maintain the environment, but that high levels of wear and tear, and of portable items being damaged or removed meant that the waiting area was now usually sparsely equipped and furniture was secured to the floor. Once children and young people have been seen for triage, there is a dedicated area for assessment and initial treatment. This is more child and family friendly, having play equipment and being more attractively decorated. However, increasing numbers of people using the service were presenting challenges in providing appropriate accommodation. There is a play area with toilet facilities although the toilets were recognised by staff to be unsatisfactory to meet the needs of families using the service. Treatment cubicles are small and close together, undermining privacy and dignity. There are two relatives room separate that are frequently used for delivering bad news and private discussions. However, the space for staff and records is cramped. There is no dedicated resuscitation area for children and young people, although there is appropriate equipment available within the general area provided, with paediatric staff and services to respond to resuscitation and the major trauma for children and young people. Staff and hospital managers are well aware of the deficits in the current arrangements and there are well-developed plans for the refurbishment of some joint areas in the emergency departments and for a new building to accommodate a dedicated paediatric service combining the emergency department and the paediatric admission and assessment wards. Refurbishment work was due to start in 2012, and building work to commence in 2013.

Outcome 12 Staffing recruitment

61. Recruitment policies across the PCT and provider trusts are of good quality and include appropriate checks and criteria.

Outcome 13 Staffing numbers

62. As highlighted in other areas of this report, action has been taken by commissioners and providers of health services to review staffing capacity across a range of services, and action has been taken to provide extra staffing where pressures have been identified that impact upon the quality or effectiveness of the service provided. However, across all health teams, the pressures of increasing demand due to rising birth rates and increasing complexity of medical and disability needs of children and young people was being felt. While health commissioners were being responsive to identified needs, the capacity of the service to continue to meet growing demand in future years was unclear.

Outcome 14 Staffing support

63. The designated doctor and nurse and the contracted-in safeguarding lead for GPs have a role in policy development, training and supervision of named safeguarding leads as well as in performance management. Appropriate priority has been given to ensuring that robust safeguarding training and supervision arrangements are in place. Good progress has been made in delivering safeguarding training to GPs and staff at their practices, although this is not yet at 80% compliance.

64. The Children's Trust provides a comprehensive range of multi-agency child protection training which promotes good partnership and networking between agencies. Staff across the partnership are readily able to access training and there has been recent success in securing attendance from independent schools in relevant child protection training.

65. The named doctor and nurse for safeguarding at Solent NHS Trust are part of a dedicated safeguarding team that includes safeguarding nurse specialists who provides training, advice, supervision and support to staff across all of the Trust's universal health services in Southampton. The work of the team has an increasing focus on ensuring that practitioners have a focus on early intervention and prevention in safeguarding children and young people. The provision of additional safeguarding training, supervision and oversight to health visiting and school nurse teams has promoted an increased focus on identification of risk, early intervention and joint working, which is being monitored to ensure that safeguarding practice is improved and embedded. Levels of uptake of safeguarding training are compliant with national guidance, and practitioners reported that training provided was of a good standard and helped them understand safeguarding responsibilities and processes.

66. Safeguarding supervision for health visitors has been strengthened, focusing on reflective practice to promote improved identification of risk and appropriate response to concerns. Practitioners across other Solent health services reported that they had good access to safeguarding supervision on request, and individuals gave examples of positive responses from named nurses or health safeguarding teams when they had done so. Currently there are no arrangements for routinely providing dedicated safeguarding supervision across all health practitioner groups, and in some teams, safeguarding supervision is combined with clinical and/or management supervision. There was insufficient capacity in the arrangements for safeguarding supervision of school nurses. The adequacy and effectiveness of supervision arrangements are subject to a review in Solent NHS Trust and a new supervision model for their service is being developed

67. The named doctor and nurse for safeguarding at University Hospital Southampton are part of a dedicated safeguarding team at the hospital that provides training, advice, and a responsive service when child protection concerns are identified. This service ensures a co-ordinated and effective response to safeguarding issues, and is highly valued by staff. Prompt action was taken by the safeguarding team to address issues identified in SCRs, specifically in ensuring robust systems for identifying risks to children and young people when adults attend the Emergency Department, which has led to a significant increase in concerns being identified and responded to.

Outcome 16 Audit and monitoring

68. The council and its partners undertake a range of performance management and quality assurance functions across agencies and within individual services. At the strategic level, safeguarding performance is monitored through the SSCB, the Children's Trust Board and the council's scrutiny committee. Through reports and its own audit activity, the SSCB maintains a close view of safeguarding performance across the partnership and has been instrumental in raising concerns about the performance of safeguarding services within the Council.

69. The designated safeguarding doctor and nurse have oversight of the implementation and effectiveness of actions taken in response to the recent SCRS, and are part of the SCR sub-committee of the LSCB who are monitoring progress across health providers. The recent re-location of the designated safeguarding posts from Solent NHS Trust to NHS Southampton PCT will enable clearer lines for reporting and accountability, and the post-holders have an increased focus on performance management and quality assurance across providers.

70. Since being established in 2010, Solent NHS Trust has reviewed its governance arrangements and established an assurance committee attended by all clinical leads. This provides a structure for scrutinising performance in activity including safeguarding, and a dashboard of performance indicators is being developed to report to the LCSB and commissioners. Clinical audits are undertaken by a quality and risk team, who oversee internal governance and reporting to the trust board. There are clear reporting lines for the Trust's response to the recent SCRs, and a panel for monitoring and responding to serious incidents requiring investigation SIRI. The Trust is undergoing significant change in establishing itself as a new organisation, merging services across Portsmouth and Southampton, and it is also applying for foundation status. It is as yet too early to evaluate the effectiveness of services, the impact of structural changes, or determine the impact of the wide-ranging actions taken in response to SCRs.

71. The acute hospital trust, University Hospital Southampton, has clear structures for assuring the quality of safeguarding for children and young people, and clear reporting lines to executive boards and to the LSCB.

Outcome 20 Notification of other incidents

72. 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

73. Health looked after children records seen were are satisfactory overall. They are child centred and indicated comprehensive assessment matched to delivery of services. Health assessments and reviews are copied to the child's GP and shared with foster carers and the young person where competent.

74. Progress in achieving the health care plan action points was recorded in different parts of the children looked after health team's records or in the child's review notes; there was no easily accessible summary or chronology which made it difficult to track outcomes in some of the health care records examined.

Recommendations

Within 3 months from the date of this report, NHS Southampton should

- Ensure that facilities for the medical examination of children and young people under 13 years of age who are the victims of abuse, including sexual assault, are available and are readily accessible at weekends (Ofsted)

Within 6 months of the date of this report, NHS Southampton should

- Review and develop the arrangements for the strategic roles of the designated leads for looked after children, to be compliant with the statutory guidance *Promoting Health*, with clear job description and lines of reporting to the PCT.
- Ensure that there is sufficient capacity within the children looked after health team to meet the health needs of children looked after
- Develop the service provided by the children looked after health team to ensure that the health needs of care leavers are adequately addressed
- Ensure that a joint strategic needs analysis is undertaken to include review of need for Tier 2 health services and access to Tier 3 services to meet the emotional, physical and mental health of children and young people, and to develop a commissioning strategy to address identified need
- Undertake further work with partners in adult health services to ensure that there are appropriate and effective protocols in place to support the transition of young people with mental health problems and physical or learning disabilities to adult health services
- Ensure that health records for looked after children include a summary or chronology

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.