Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Royal Borough of Kensington & Chelsea

Date of Inspection	10th April 2012 – 20th April 2012
Date of final Report	29th May 2012
Commissioning PCT	Inner North West London PCT (INWL) part of the North West London Cluster of PCTs
CQC Inspector name	Jan Clark
Provider Services Included:	Central London Community Healthcare NHS Trust (CLCH) Urgent Care Centre and A&E at Chelsea and Westminster Hospital NHS Foundation Trust Central North West London Mental Health Trust (CNWL) Urgent Care Centre at St Charles Hospital
CQC Region	London
CQC Regional Deputy Director	Matthew Trainer

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 .

Royal Borough of Kensington & Chelsea Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	GOOD
Capacity for improvement	GOOD
The contribution of health agencies to keeping children and young people safe	GOOD
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	GOOD
Capacity for improvement of the council and its partners	GOOD
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:

The Royal Borough of Kensington and Chelsea has a resident population of approximately 30,340 children and young people aged 0 to 18, representing 17.9% of the total population of the area. In 2012, 76% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall and 54% of pupils speak English as an additional language. Pupils in the borough's schools speak a total of 107 languages other than English. Arabic, Spanish and Portuguese are the most commonly spoken community languages in the area.

The Children's Trust was set up in 2008. The borough reviewed its Children's Trust arrangements in 2011 replacing the Board with a commissioning group and network. The network brings together the main statutory and voluntary organisations working with children, young people and families bi-annually. The safeguarding children board became independently chaired in 2009, bringing together the main organisations working with children and families in the area that provide safeguarding services. At the start of April 2012 the borough established a single Local Safeguarding Children Board (LSCB) with neighbouring boroughs Hammersmith and Fulham and Westminster as part of the tri-borough arrangements. A joint LSCB training programme has been in operation across the three boroughs since April 2011.

Community-based children's services are provided by 6 locality based social work teams in the Family Services directorate. They are supported by teams for children with a disability, the Health-Link team based at the Chelsea and Westminster Hospital, and youth offending, adoption and fostering services which are now tri-borough services. There is an emergency out of hours service providing cover for the borough. Other family support services are delivered through 8 children's centres and extended services in schools. At the time of the inspection a proportion of this service offer was subject to re-design to form an integrated all-ages early help service. In addition there is a range of play and youth provision in the borough along with specialist services such as teenage pregnancy.

At the time of the inspection there were 134 looked after children. The borough's Independence Support Team works with 136 care leavers. At the time of the inspection there were 86 children who were the subject of a child protection plan. This is a slight decrease over the previous two years.

In April 2011, as part of the NHS Reforms and the London wide NHS management cost reduction programme, Hammersmith & Fulham PCT joined with Kensington and Chelsea and Westminster PCTs to form Inner North West London PCTs (INWL). INWL PCTs is part of the North West London Cluster of PCTs. Some functions are now dealt with at a North West London cluster level e.g. acute commissioning and primary care. Three clinical commissioning groups (CCGs) have been established across Inner North West London and are beginning to take on commissioning responsibilities. The West London CCG covers all of Kensington and Chelsea and also part of Westminster that borders RBK&C from the north. Until April 2013, commissioning for children and young people is being carried out by the INWL PCTs Children's and Sexual Health Commissioning Team. Commissioners from this team are now involved with all three CCGs.

Universal health services such as health visiting, school nursing are provided by Central London Community Healthcare NHS Trust (CLCH) which also provides speech and language services. Occupational therapy is provided by CLCH and Imperial and physiotherapy by Chelsea & Westminster and Imperial. The acute hospital providing accident and emergency services for children is Chelsea and Westminster Hospital NHS Foundation Trust. Families in North Kensington also use the nearby St Mary's Hospital (Imperial) in Paddington. There are two specialist acute hospitals: the Royal Brompton and Harefield NHS Trust and the Royal Marsden NHS Foundation Trust. Community-based Child and Adolescent Mental Health Services (CAMHs) are jointly commissioned with RBK&C children's services (FCS) and are predominantly provided by Central North West London Mental Health Trust (CNWL). Adolescent In-patient CAMHS is provided by the Priory Group. Pre-adolescent in-patient services are provided by Collingham Child and Family Centre which is managed by CNWL NHS Foundation Trust.

Children and families access primary care services through 44 GP Practices, 18 dental practices providing NHS services, 39 community pharmacies and over 30 optician services. There are two Urgent Care Centres at Chelsea and Westminster Hospital NHS Foundation Trust and St Charles Hospital. Maternity and newborn services are predominantly provided by Chelsea and Westminster Foundation Hospital Foundation Trust. Kensington and Chelsea families also use St Mary's Hospital and Queen Charlottes at Hammersmith Hospital (Imperial). A proportion of mothers (35%) also choose either a private hospital birth or a private birth in an NHS hospital. The borough has the highest life expectancy across the country and child mortality rates are lower than the national average.

Safeguarding professionals operate as a team in INWL Public Health supported by a team administrator. The executive board lead for safeguarding is the director of public health and the safeguarding team is managed by a consultant in public health. The INWL safeguarding team structure is as follows:

- Designated doctor, designated nurse for safeguarding children and a named GP for each of the three boroughs.
- Deputy designated nurse for each borough who works closely with the designated nurses.
- Designated doctor for unexpected child deaths covering INWL.

Two looked after children's nurses are provided by Central London Community Healthcare NHS Trust jointly commissioned by FCS and INWL PCT. There are two designated looked after children consultants. The designated looked after children nurse manages a named looked after children nurse and the clinical psychologist for looked after children. The majority of Kensington and Chelsea's LAC population are placed out of borough- 26.7% are placed in borough with a further 41.7% in greater London and 31.5% outside of London

Services for children with learning difficulties and complex health needs are commissioned from a number of providers. Two child development teams (CDT) provide diagnostic, treatment and support services for children with complex health needs. In North Kensington the CDT is provided by a combined CLCH and Imperial College Health Care team. Chelsea and Westminster Hospital provide a similar service to young people in the south of the borough with input from CNWL (psychology) and CLCH (speech and language).

General – leadership and management

1 The PCT, NHS Kensington and Chelsea was ranked 2nd in the sector and 4th in London in 2010, making it one of the top performing PCTs in London. It brings this history of positive performance and service delivery to the Inner North West London PCTs (INWL) which incorporates Kensington and Chelsea, Westminster and Hammersmith & Fulham PCTs. The local authority and health agencies have a shared ambition and vision which underpins strong partnership arrangements. Together the partnership has delivered a sustained track record of achieving good outcomes for children who need safeguarding and protecting, or who are looked after. The inspection judged the overall effectiveness of safeguarding services as good and the contribution of health to children's safeguarding is also good. For looked after children, healthcare provision is good. Universal health outcomes for immunisations, completion of annual health assessments and dental checks are in line with, or better than, comparator authorities.

2 The PCT and health service providers play a key role in the Commissioning Group and supporting Network which replaced the Children's Trust in 2011. The strategic clinical health perspective is not routinely represented at the corporate parenting board however, as the looked after children nurse's engagement with the board is at the board's request only.

3 The development of the tri-borough arrangements alongside the INWL is innovative. These offer good opportunities to strengthen services, for example the single local safeguarding children board and development of the INWL safeguarding team, while achieving savings through economies of scale. These include merging 'back office' functions and building operational capacity to introduce focused support to primary care independent contractors through the introduction of the deputy designated nurse role. There is scope for the partnership to capitalise further on opportunities presented by the organisational changes across health and social care. An example being; to engage education more strongly in the integrated working between health and social care for children with disabilities.

4 Safeguarding policies and procedures are up to date across the health community and practice is continuously improved by lessons learnt from research as well as from national and local incidents. Within the PCT Cluster and tri-borough arrangements, the designated nurse provides effective and supportive leadership as well as robust challenge to health service providers. LSCB and INWL governance arrangements are in place and effective in identifying and addressing any areas for development.

Outcome 1 Involving Users

5 The views of children, their parents and carers are actively sought by councillors and professionals as part of commissioning and there is clear evidence of these consultations directly influencing and shaping service provision. For example St Quintin's, an open access centre for children with disabilities, was commissioned and launched with the full involvement of service users and their families.

6 Kensington and Chelsea now has the lowest rate of teenage pregnancies per 1,000 women aged 15-17 in London, and the latest data shows further improvements to a rate of 21 teenage conceptions per 1,000 women aged 15-17 in 2009, from 25.6 in 2008. This target is based on ensuring expectant mothers have an ante-natal assessment of health and social care needs within 12 weeks and six days of conception. Performance on this parameter has improved to 91.4% in 2010/11, from 78.6% in 2009/10.

7 In relation to health assessments for looked after children, choices are given to young people about the gender and culture of the assessor and the location of the health assessment. These take into account the circumstances of the young person and their foster carer, for example; a home review being offered when the foster carer was unwell. A more flexible approach to late attendances at clinics by young people has been adopted.

8 Copies of statutory looked after children reviews are accessible to the looked after children health team and these are routinely discussed at the looked after children health team's monthly caseload meeting to identify any issues to follow up at the health review. However, the potential to use strengths and difficulties questionnaires (SDQs) within health reviews as a tool for young people to evaluate their own personal emotional development over time is not sufficiently exploited.

9 Young people are increasingly engaging with the Being Healthy agenda and their contributions are informing service development. The looked after children website was created in 2011 by looked after children and a health consultation was undertaken with the Children in Care Council last year.

10 Where young people are engaged with the substance misuse service, they are central to the development of their support plan and routinely review their own progress and re-determine their goals during the four to six months intervention. The service provides training and facilitates discussions with young people in schools and residential settings as well as independent living placements. There are also good links into the youth offenders' institution at Feltham where individuals are supported by a specialist substance misuse worker. Young people routinely inform service development and requests to provide advice and support groups of young people are responded to positively, a recent example being engagement with a group of young people in hostel accommodation.

11 Successful service engagement recently with the traveller community in the area is beginning to facilitate increasing health promotion work with young travellers including sexual health and substance misuse. A three-monthly multi-disciplinary meeting held on the site continues to strengthen community engagement. A specialist health visitor and school nurses are also successfully engaging with the community contributing to significant increases in school attendance, improved oral health and increased uptake of immunisations.

12 Young people's feedback to the sexual health service indicates a satisfaction with the service of 97%, up from 94% four years ago. The service uses Facebook, Twitter and 'textmate' whereby young people can text in questions about sexual health, to good effect to engage young people. The advisors working with Living Well, a community interest company which provides this texting service, are themselves ex-service users of teenage pregnancy support services. The service is working on the "You're welcome" criteria but is not yet accredited. Young inspectors have been trained and have had positive impact, particularly on the environment leading to the provision of a health room at the community centre and the establishment of the LGBT group. Sexual bullying is an identified issue locally and a "Girls Allowed" event for young women up to age 25, their parents and carers was attended by 120 people and addressed domestic violence as well as sexual exploitation. Engagement with pharmacists is currently underdeveloped and is acknowledged as a priority area for development.

Outcome 2 Consent

13 Evidence for parental consent to health assessments and treatment for looked after children is evident on some health records but not consistently across the case sample evaluated.

Outcome 4 Care and welfare of people who use services

14 There have been a range of joint initiatives to improve health outcomes for young people. For example; poor oral health has been identified in primary school children and is a local priority in the joint strategic needs assessment (JSNA). In late 2010 the Bigger Smiles programme was piloted at a primary school in Earls Court. The programme is based on the Scottish Childsmile service aiming to improve the oral health of children from birth to 8 years. With sponsorship from a pharmaceutical company, a theatre performance introduced children to good brushing habits. Children then received a dental check up and fluoride varnish application, and were given goody bags with character toothbrushes and toothpaste to take away. The pilot's success was evidenced by the high positive consent rates which saw over 95% of children receive the check up and varnish.

15 Immunisation rates for children in the general population are below England averages thought to be due, at least in part, to pockets of deprivation and mobility within the community. Current performance for measles, mumps and rubella (MMR) at two years is 77.4% compared to London average 80.8% and England average 88.2%. At five years the rate is 60.8% compared to London average 71.2% and England average 82.7%. There are high levels of childhood obesity at year six, identified as an area to be addressed within the JSNA. The level of children participating in at least three hours of sport per week is 77%, above the national average.

16 Over the last three months, the system for social workers to notify the health team of children and young people entering or leaving care has been tightened to ensure initial health assessments can be triggered for completion within the required timescales. The impact of this improvement will continue to be monitored and reported upon in the annual looked after children health report.

17 Health assessments are good quality; comprehensive and detailed. In the case sample, there were examples of the looked after children nurse sending a clear 'prompt' list to the social worker to trigger necessary information gathering or actions prior to the health assessment. The designated doctor pays close attention to the individual child's needs, diligently following up an anomalous height record for one child and exploring the impact of bereavement due to gang violence with another. Where a child with disabilities was engaged with several service providers, resulting in service overlap and complexity, the looked after children health team acted as an effective catalyst to rationalise service provision and services for this child are now delivered by a single provider.

18 Most health reviews are undertaken by the looked after children health team, including those for children placed outside the Royal Borough's boundaries. The personality and individuality of the child is well reflected in records and the wishes and feelings of the child or young person is identifiable. The resultant health care plans are informed by relevant information held in social care records to which the looked after health team have access.

19 Recently, the looked after children health team has introduced a new template for health plans derived from the health assessment documentation and this is a very positive development. Health plans are good quality overall and one plan seen during the inspection was outstanding. This plan set out clear and measurable health outcomes rather than simply a list of tasks or clinic appointments; health care plans attribute roles and responsibilities to named individuals for delivery and monitoring frequencies are specified. Liaison between the looked after children health team, other health professionals and social workers working with the individual child is effective in ensuring that the health needs of the child are identified and met. One case in the sample was outstanding. Highly effective multi-disciplinary work in close partnership with prospective adopters resulted in a baby being successfully placed for adoption in the family who had previously adopted the baby's siblings.

20 Health reviews are comprehensive with sensitive, age appropriate exploration of risks and personal safety concerns. This extends to well evidenced discussions about e-safety, sexual health and gang culture, particularly where the child or young person has known victims of violence personally. Imaginative methods are used to try to engage resistant young people with the health planning process and there is evidence of some good successes with individuals. For example, some health reviews have recently been conducted by the looked after children nurse by telephone. This successfully secured the engagement of the young people and facilitated discussions on sexual health and risk taking behaviours. Feedback from the young people engaged by telephone, has been positive.

21 Good quality child and adolescent mental health services (CAMHS) are in place. CAMHS support to schools has strengthened early intervention for young people with mental health needs Access to CAMHS works well during day time hours, with a response to requests for assessment within half an hour. Where a child has self-harmed the CAMHS team undertake joint assessment with the hospital social work team, Healthlink, with which they work closely. Access to out of hours mental health assessment is more complicated with a three stage process in place operating across several boroughs and hospital sites which can result in delays and potentially avoidable admissions. The work required to improve this situation has been recognised and is underway.

22 Looked after children do have prompt access to a specialist psychology service, which mostly works with foster carers to support fragile placements. Examples of positive outcomes included one young person in a residential placement at risk of breakdown due to challenging behaviour having significantly improved behaviour and demonstrable emotional wellbeing that they are now able to attend essential hospital outpatient appointments, not possible previously. A second psychology post is being recruited to which will provide life coaching and psychological support to older looked after children and care leavers. Psychological screening of all looked after children under five years old is being introduced as part of early intervention work. Work is also undertaken with Feltham young offenders' institution and with residential homes. When young people placed out of borough are not able to access CAMHS in that area, the PCT commissions private provision to ensure the child's needs are met.

23 The Central North West London Mental Health Trust (CNWL) is currently reviewing the provision of accommodation for young people held in custody while waiting for, or undergoing a mental health assessment. Where young people need inpatient treatment for mental health problems, access to specialist in-patient provision has been a longstanding challenge with the service being contracted from outside of the borough. Capacity is limited and this has resulted in young people waiting for up to 14 hours in acute hospital settings for an appropriate bed to become available, putting additional pressures on acute hospital staff and managers to safely support the patient. Contingency support plans are in place to manage risks when these situations arise. No child has been admitted to an adult ward in the last 12 months. Concerns about the quality and level of therapeutic input and safety measures at the in-patient treatment facility for children over 12 years old have been identified by CNWL and other stakeholders, but good work by the trust with the specialist commissioning group has led to recent improvements. Discharge planning is a strength however. When a child is discharged from Tier 4 provision, they are automatically regarded as a child in need and referred to the locality social work team to ensure positive re-engagement with family and community.

24 There is a range of effective, accessible, multi-disciplinary substance misuse and sexual health services operating in partnership with social care, schools, the pupil referral unit, the youth service, youth offending and the voluntary sector. These provide flexible and responsive outreach services resulting in positive outcomes. Currently 60 under 18s are actively engaged with the specialist substance misuse service run by Insight either through the mainly outreach support or the drop-in, Hot Cafe. All looked after children are assessed for substance misuse through a screening tool and there is a specialist worker for looked after young people aged over 16. Rates of hospital admissions for accidents, injuries and alcohol for young people are very low although this has risen over the past year. Protocols are in place with adult services to guide work around hidden harm to children as a result of adult drug use although the service finds it difficult to obtain good data from adult services on children being cared for by adults who are misusing substances. This can be particularly challenging where children are in the household of grandparents who are misusing drugs or alcohol.

25 Co-operative working between the substance misuse service and sexual health advisors is routine. The incidence of teenage pregnancies has been successfully reduced to a very low level at 0.5% of all births and the Royal Borough of Kensington & Chelsea now has the lowest rate of teenage pregnancies per 1,000 women aged 15-17 in London. There are currently seven care leavers who are pregnant or are young mothers and one young father being supported by the leaving care team (IST). The new FNP will provide support to young fathers to learn parenting skills and services developing at the children's centres include support to young fathers through Saturday morning fathers' groups.

26 Sexual health services are working well with youth clubs, in partnership with Connexions and the community centre which offers a range of health services, including support to LGBT groups. The service operates closely with school nurses and is building positive engagement with schools although there continue to be challenges in this work as some schools are reluctant to engage. Colleges have undertaken educational visits to the sexual health clinic. Service delivered to the PRU by an independent provider is effective in identifying other issues and signposting young people to appropriate services such as mental health and substance misuse.

Outcome 6 Co-operating with others

27 Health staff are routinely involved in child protection case conferences. Their contribution is valued and they feel part of the decision making process leaving conferences clear on their role and responsibility for the protection plan. Health visitors and school nurses prioritise child protection and safeguarding activity and work well in partnership with other professionals. Attendance at child protection conferences is good and subject to close monitoring through the PCT governance arrangements.

28 The development of multi-disciplinary 'early support' services are successfully supporting children and vulnerable families in lower level services and facilitating step-down from child protection procedures. Staff cited a number of examples of these positive outcomes for vulnerable children and their families. This has been achieved by building on the Aiming High investment for children with disabilities, released funds from reconfigured services have been re-invested to provide additional occupational therapy, speech and language, physiotherapy, play and specialist health visitor key workers.

29 The process of ensuring that notifications for children entering or leaving care and changing placement are made promptly to the looked after children health team has not been operating effectively until very recently. As a result, initial health assessments (IHA) have not routinely been completed within 28 days of the child entering the care system. Within the last 3 months, the system has been modified for notifications to automatically be sent to the designated looked after children nurse who then initiates a trigger letter and documentation for IHA to be undertaken. This has resulted in recent improved performance on IHA being completed within timescales.

30 All initial and review health assessments are undertaken by suitably qualified health professionals under the direction and oversight of the designated doctors, designated nurse and looked after children nurse team. In the past year, all except 15 health assessments out of 175 have been undertaken by a team member, and wherever possible the team is committed to continuing to assess the needs of all looked after children, including those placed out of area. Quality assurance of plans is undertaken by the looked after children health team although this is not strongly evidenced on case records.

31 Specialist health provision from a dedicated nurse is available to looked after children receiving services from the youth offending team. In addition, the looked after children psychologist provides prompt and effective support particularly to foster carers and there is strong evidence that this helps sustain placements which have become vulnerable to breakdown. Foster carers have good access to training on healthcare issues. The service also works with individual children, including those placed outside the area. Close co-operation between the virtual school and the looked after children health team ensures that there is an effective multi-disciplinary approach to meeting the child's needs, wherever they are placed. This is facilitated by the comprehensive nature of health assessments and strengthened approach to the resultant health planning so that all relevant professionals are very clear on what they need to do to deliver good health and wellbeing outcomes for the young person.

32 Targeted and age appropriate health promotion information and material is distributed routinely to looked after children at their health reviews and also delivered in a range of settings in response to specific requests from looked after children and care leavers. A recent 12 week programme for a girls' group in a residential home encompassed topics including self-esteem and healthy eating. All looked after children who are over 16 and access sport and leisure facilities within the Royal Borough are provided with a pass to promote healthy lifestyles. Those placed outside of the borough are funded to enable them to participate in similar activities in their localities.

33 For children with disabilities, clinical interventions are increasingly being co-ordinated to reduce the trauma and complexity of arrangements for individual children with examples being given of positive outcomes. A review of the provision for child development is due for completion shortly with commissioners expecting this to inform progress towards a fully integrated service across the borough which has been inhibited by historical structural and professional arrangements.

34 The co-location of the social work team at Chelsea & Westminster Hospital facilitates effective communication and operational co-operative working spoken of in very positive terms by both health and social care staff. Although the looked after children health team are co-located with the independent reviewing officers (IRO) and relationships are reported to be good, the annual IRO report does not include the effectiveness of healthcare delivery and there are not regular meetings between the teams.

35 Work is also in progress to address historic inequalities between the north and south of the borough in relation to the provision and effectiveness of the interface between midwifery and health visitor services. Historically, this has worked more effectively in the south due to differences in resourcing. To help address this, a new anti-natal pathway is being rolled out from Hammersmith & Fulham to ensure a joint visit by the health visitor and the midwife takes place at 35 weeks followed by a joint visit at 4-5 days rather than 10 days post-natal.

Outcome 7 Safeguarding

36 The development of INWL and the tri-borough arrangements is bringing positive opportunities to develop consistent high quality, multi-agency approaches to the safeguarding of children and young people. Within the arrangements, the designated nurse is providing effective and supportive leadership and robust challenge to health service providers. This provision has been strengthened through the recent appointment of a deputy designated nurse focusing on the safeguarding practice and performance of independent contractors.

37 The looked after children health team know their children and young people well and are diligent in following up health issues or non attendance at health appointments. Members of the looked after children health team, including the designated looked after children nurse, work closely with individual children and young people to encourage them to actively engage with health services and there are positive outcomes from this ‘hands on’ approach.

38 Front line health staff have access to safeguarding policies and procedures to guide their day to day practice. Staff across the health community are aware of their roles and responsibilities regarding safeguarding with an example being school nurses engagement in anti-bullying strategies and recent involvement in a case of sexual exploitation in school. Practice is continuously improved by lessons learnt from research as well as from national and local incidents. Policies governing provider services response to non-attendance of children at medical appointments are in place and acted upon. Awareness of risks for home educated children is of particular relevance in the area, although identifying the cohort is challenging. Health staff are playing an active role in ensuring the protection of the health and wellbeing of such children, an example being given of a school nurse liaising with social care over children with disabilities who are being home educated. There is good access to knowledgeable named and designated professionals who are leading practice development and performance improvement well.

39 General practitioner (GP) engagement in safeguarding arrangements is under developed although there have been improvements from a very low base, over the past year. This has been driven by the LSCB through the designated PCT leads and the appointment of a named GP. Invitations to case conferences are now being sent electronically which addresses the previous irregularity of invitations reported by GPs. This development will facilitate attendance. The January 2012 appointment of a deputy designated nurse focused on developing the safeguarding practice of independent contractors in primary care is further strengthening both support and challenge to practitioners. A section 11 audit tool for practices has been introduced, each general practice now has an identified safeguarding lead and uptake of training has increased recently. The new named GP has instigated a GP safeguarding forum to drive improvement with seven out of forty-three practices attending the first meeting. However GP engagement has not had a high profile to date within the clinical commissioning group (CCG) and is not yet addressed through appraisal.

40 Dentists are not yet engaged with local safeguarding arrangements and neither the LSCB nor the PCT has communicated its expectations of them effectively. Dentists the inspector met had a low awareness of the work of the LSCB and outcomes from the child death overview panel (CDOP). They were unaware that the LSCB has set an expectation that all practitioners will attain level three safeguarding training. Training for dental surgeons was arranged by the PCT two years ago since which time, dentists have been arranging their own safeguarding training. A dental forum had met regularly which the practices engaged with it had valued although this is currently in abeyance since the merger of the PCTs which previously facilitated it. The local dental council is well attended and there is scope to develop this forum to support dentists safeguarding knowledge and practice.

41 Safeguarding arrangements and systems to identify potential safeguarding risks to children are well established at the urgent care centre at Chelsea & Westminster Hospital and action is progressing to strengthen similar arrangements at St Charles Hospital. While there is good attention to risk evaluation at the point of clinical assessment, this is not yet routine at front desk registration. Both the school nursing service and local hospitals are diligent in checking on whether any children brought to their attention are attending school. The input of the health visitor liaison at Chelsea & Westminster is highly valued by practitioners, having high visibility and acting as an effective source of advice, guidance and quality assurance activity. Safeguarding arrangements at the children's accident and emergency department at Chelsea & Westminster Hospital NHS Foundation Trust were found to be effective in both the Hammersmith & Fulham and the Westminster inspections and these services were not revisited.

42 Midwives within the maternity services have a good awareness of safeguarding risks and what indicators to look for. Priority given to improving performance on registrations at 12 weeks plus six days across services is being strengthened further by the service aiming to register expectant mothers at 10 weeks. Monitoring of this by INWL across Chelsea & Westminster, Queen Charlottes and St Mary's hospitals is rigorous. Effective pre-birth planning with social care routinely takes place in a multi-agency approach and an effective policy is in place to identify appointments that had not been kept. The vulnerable women's forum at Chelsea & Westminster facilitates multi-agency discussion and risk identification leading to positive interventions. There is good awareness of cultural issues across maternity services including attitudes to children born with disabilities. Specialist female genital mutilation midwifery services at Chelsea & Westminster and Queen Charlottes sees women at 16 weeks ante-natal and continue to support through delivery and beyond. Where female babies are born to these women, there is a strong multi-disciplinary approach to risk assessment. Staff prioritise the provision of independent interpreters over use of family members and some multi-lingual practitioners and an Arabic speaking midwife at Queen Charlottes is particularly helpful in ensuring expectant mother's voices are heard. A family nurse partnership service (FNP) is in the early stages of being rolled out across Kensington & Chelsea under the new health economy arrangements.

43 While inspectors saw examples of positive practice, there is inconsistency in the engagement of adult services in assessments of parenting capability and occasions when adult workers do not prioritise the needs of the child. Not all teams have safeguarding children's champions and not all front line staff have undertaken children's safeguarding training at a level commensurate with their roles. Protocols are in place however, to guide adult service workers in identifying children at risk of hidden harm in a household where an adult is accessing mental health, adult disability or substance misuse services. Assessment documentation contains triggers and child safeguarding is routinely discussed in supervision and team meetings. Joint work is undertaken by children's and adult workers in response to individual need or where a protection plan is in place. To strengthen Think Family approaches the CNWL is recruiting a dedicated think family project leader to ensure the approach is embedded.

44 The child death overview panel (CDOP) is effective, operating in a tri-borough partnership with Westminster City Council and the London Borough of Hammersmith & Fulham. During the year the CDOP was notified of 174 deaths of children (176 the previous year): 22 usually lived abroad and 117 in other parts of the UK and 35 children died who were residents of the tri borough area. The annual report is presented to the LSCB executive and posted on the website although it is not clear how effectively this is conveying information of the outcomes of the panels' work to frontline health services as the CDOP currently has a low profile across most health services.

45 When young people have been the victim of sexual assault, access to specialist services is well established and effective with positive follow-up communication between consultant paediatricians and the child's GP. Good quality sexual assault referral centre (SARC) provision is provided by The Haven at St Mary's Hospital and follow up support and sexual health advice is provided. When a young person is taken to The Haven and substance misuse issues are identified, prompt access to specialist substance misuse support is also provided.

Outcome 11 Safety, availability and suitability of equipment

46 No issues were reported with procurement of equipment within children's services or the A& E departments of the acute trusts. Paediatricians and specialist professionals visit schools and work with school staff on how best to support children with complex health needs, including how to operate and maintain equipment.

47 There is appropriate provision of equipment at the urgent care centre at St Charles hospital, checked on a daily basis. The new manager is experienced in safeguarding practice and is leading service improvements effectively, including improved provision of patient information to match demographic need and improved screening for domestic violence and introducing staff supervision. The provision of tear off slips in patient lavatories which give information on how to contact support against domestic violence is innovative and their value to patients is evident. An appropriate flagging system is in place to alert staff to children known to services which operates across CLCH services. This does not currently identify looked after children however. Each room in the centre has a safeguarding flowchart to guide clinicians' practice. There is more to do to ensure effective risk assessment at the point of patient registration.

48 The urgent care centre at Chelsea & Westminster Hospital provides good visibility of the waiting area to reception staff and standardised questions at registration facilitate risk identification. Staff make sensitive provision for young people with ADHD, autistic spectrum disorders (ASD) or Asperger's syndrome who find the busy environment upsetting, using quieter cubicles and fast tracking and making good use of the large fish tank in the hospital foyer which demonstrably calms anxious or distressed children.

49 Safeguarding arrangements at Chelsea and Westminster Hospital NHS Foundation Trust were found to be effective in children's service inspection undertaken in both Hammersmith & Fulham (July 2011) and the Westminster inspection (September 2011). The department was not revisited for this inspection, however confirmation that arrangements continue to be effective was established through focus groups and documentation.

Outcome 12 Staffing recruitment

50 Health staff in provider services are CRB checked at enhanced levels on recruitment, in line with minimum national requirements. No issues relating to recruitment practice across health providers have been identified.

Outcome 13 Staffing numbers

51 INWL PCT, through the Central London Community Health Care NHS Trust (CLCH), currently funds RBK&C 25.27 WTE qualified Band 6 and 7 health visitors, a number of health visitor assistants and support staff. The service is projected to need 45.1 WTE qualified health visitors, almost double the current posts. In 2011, CLCH allocated 18 new health visitor training places.

52 The health visitor implementation plan for INWL PCT sets out a comprehensive analysis of demographics, deprivation and morbidity. It links this analysis to national recommendations for lower caseloads generally (<400 cases) and targeting resources at areas of higher deprivation and therefore greatest need (<100) relating the impact of deprivation on child health and vulnerability in order to identify 2015 workforce targets. The service's trajectory is on track to achieve the identified required staffing levels and skill mix.

Outcome 14 Staffing support

53 Safeguarding training of health staff across the health community at the levels appropriate to their role is in place and take up is good. It is rigorously monitored through provider trusts and the designated nurse and the LSCB. Priority is being given across services to raise awareness of domestic violence and services are well engaged with MARAC. Training on domestic violence has been recognised as a priority area for development at the UCC at St Charles Hospital and is being addressed. Safeguarding training is raising awareness across services on specific topics including issues around sexual exploitation. Whereas hospital based midwives have undertaken common assessment framework (CAF) training, community midwives have not. CAF is not currently well established in the Royal Borough.

54 Named safeguarding professionals are well supported by the designated leads and by their own organisations to discharge their responsibilities and access support. Leads are well engaged with local and regional safeguarding networks and receive regular individual and group supervision. An example of this is the weekly 'safety net' meeting held on the paediatric wards at Chelsea & Westminster Hospital which as well as reviewing cases for any safeguarding issues, serves as a valued group supervision and reflective practice opportunity attended by social workers as well as health professionals.

55 The provision of safeguarding supervision as set out in Working Together is not yet established across the entire health community however. Supervision is well established in community health services where health visitors and school nurses receive regular individual safeguarding supervision, at the Chelsea & Westminster hospital in both accident and emergency, the urgent care centre and across maternity services where this is multi-disciplinary in nature involving the health visitor liaison and led by the named nurse. It is not yet established in the urgent care centre at St Charles hospital where it has just been introduced on a group basis. Opportunities for non-clinical staff to access reflective safeguarding supervision forums to build on their training and to develop their confidence and awareness are not currently available across all services.

Outcome 16 Audit and monitoring

56 Health commissioners and providers have a good understanding of areas for development and are engaged in addressing these together. Poor performance on the performance on completion of initial health assessments within 28 days of the child entering care has been addressed and an improved process of notification by social care introduced recently. More rigorous monitoring of the outcome of the process been introduced by the designated leads and will be reported on in the next annual LAC health report.

57 The annual report on services to looked after children produced by the IROs is not informed by aggregated data from the work of the looked after health team. The most recent report made no reference to the work of the team or its outcomes and there are no regular meetings between the health looked after children team and the IROs which is a gap and surprising considering the co-location of the teams and the positive relationships that have been formed.

58 As Kensington and Chelsea have not had any serious case reviews (SCR's), the multi-agency policy procedure and practice subcommittee of the LSCB has looked at the learning of other SCR's undertaken nationally and explored whether the learning identified could be relevant locally. An example includes identifying the need to explore home schooling and safeguarding and this is being taken forward under the tri-borough arrangements. The sub-committee focused on the learning identified from one Independent Management Review and one Individual Management Review completed locally. Both reviews created action plans disseminated to agencies to raise awareness and inform practice development.

Outcome 20 Notification of other incidents

59 There are satisfactory arrangements in place across INWL, the 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.

60 No issues have been raised during the inspection in relation to notifications. Currently NPSA data definitions for moderate and abuse (which includes notifiable incidents as defined by the regulations) are broad. New guidance is to be provided to trusts reiterating the definitions of classifications following the NHS commissioning body taking over control of NPSA.

Outcome 21 Records

61 The standard of recording is satisfactory overall although where a child has complex needs it is difficult to extract information from the record to track the child's journey through the health and social care services as a looked after child. Records did not appear to fully reflect the quality assurance activity undertaken by the looked after children health team and this could be more clearly evidenced. The child's legal status is set out clearly and the use of the British Association for Adoption and Fostering (BAAF) documentation promotes a consistent approach enhanced by the recent development of the additional template for health plans. This is facilitating clear designation of responsibilities to foster carers and professionals engaged with the child.

62 Strengths and difficulties questionnaires (SDQs) and copies of statutory LAC reviews are not held on the health record, although the LAC health team have access to them through the social care information system and use them in their regular discussions of future health reviews. To date, these have not been used within the review to enable young person to track their own emotional development.

Recommendations

Immediately

- *Inner North West London PCTs and the urgent care centre, St Charles Hospital should ensure that staff are undertaking robust safeguarding risk assessment when registering children and young people for treatment. (Ofsted May 2012)*

Within 3 months (from report)

- *The local children's safeguarding board and Inner North West London PCTs should ensure that general practitioners (GPs), dentists and all appropriate health practitioners are fully engaged in safeguarding arrangements. (Ofsted May 2012)*

- *Inner North West London Primary Care Trusts (PCTs) should ensure that all clinical and non-clinical staff in health provider organisations who have significant contact with children and young people have access to regular, planned safeguarding supervision and opportunities for reflective practice. (Ofsted May 2012)*

- *Inner North West London PCTs and Central London Community Healthcare NHS Trust should ensure that strengths and difficulties questionnaires are used to enable young people to monitor their personal emotional development. (Ofsted May 2012)*

- Inner North West London PCTs and Central North West London Mental Health Trust, Chelsea and Westminster Hospital NHS Foundation Trust and St Charles Hospital Trust and other partners should consider ways to further ensure that where an adult is accessing health services, potential risks to the health and wellbeing of children and young people are fully identified and addressed.

- Inner North West London PCTs and Central London Community Healthcare NHS Trust should ensure that actions are continued to engage schools, colleges of higher education and pharmacists in the provision of effective sexual health services.

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.