

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

Date of Inspection	21st May 2012 – 1st June 2012
Date of final Report	10th July 2012
Commissioning PCT	NHS Southwark
CQC Inspector name	Lynette Ranson
Provider Services Included:	Guy's and St Thomas' NHS Foundation Trust Kings College Hospital NHS Foundation Trust South London & Maudsley NHS Foundation Trust
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](#)

London Borough of Southwark	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Outstanding
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. One letter was received during the inspection period.

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:

Southwark has a resident population of approximately 61,600 children and young people aged 0 to 19, representing about 21% of the total population of the area. In January 2012, 78.7% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall; 43.4% of pupils speak English as an additional language. Yoruba (5.9%) and Spanish (3.0%) are the most recorded commonly spoken community languages in the area. Some 12.8% of pupils are of Nigerian background.

The Southwark Children and Families Trust (SCFT) was set up in 2004. The Trust includes representatives of the London Borough of Southwark and Southwark Primary Care Trust services. Other representatives include the Metropolitan Police, Guy's and St Thomas' NHS Foundation Trust, Southwark Safeguarding Children Board (SSCB), Southwark Youth Council and representatives of local schools and colleges. The SSCB has been independently chaired since October 2009, and brings together the main organisations working with children, young people and families in the area that provide safeguarding services.

At the time of the inspection there were 546 looked after children. They comprise 121 children less than five years of age, 332 children of statutory school age and 93 post-16 young people. In addition, there are a total of 363 young people with care leaver status. Southwark uses a virtual school approach in its support of the learning of looked after children.

Commissioning and planning of health services and primary care are carried out by Southwark NHS Primary Care Trust (PCT). The main providers of acute hospital services are Guy's and St Thomas' NHS Foundation Trust and Kings College Hospital NHS Foundation Trust. Community services are provided by Guy's and St Thomas' NHS Foundation Trust. Community-based child and adolescent mental health services (CAMHS), including in-patient, are provided by South London and Maudsley NHS Foundation Trust. [Ofsted 2012](#)

At the time of the inspection, a clinical commissioning group co-terminus with borough boundaries had been established and was meeting regularly.

1. General – leadership and management

1.1 The contribution of health agencies to keeping children and young people safe is good. NHS Southwark is part of the NHS South East London Cluster. Safeguarding is the responsibility of the Chief Executive for the cluster with local accountability held by the Managing Director of NHS Southwark. Good arrangements are in place across the cluster and within Southwark to support safeguarding practice across NHS providers. Preparations are well underway for the proposed health reforms from April 2013 with the Southwark clinical commissioning group in place, made up of GPs and other clinicians who meet frequently. A nominated GP clinical lead for safeguarding is a member of the Children's Trust Board and the Southwark Safeguarding Children Board (SSCB) and provides clinical leadership and advice and support for primary care.

1.2 Strategic partnerships, including with the mental health partner, are good. Key arrangements include the Children's Trust and SSCB are working well in improving outcomes for many children and their families. The shared vision and commitment to ensure effective safeguarding are given high priority across the partnership. Joint working between health and other agencies is good, with executive directors and chief executive officers reporting good levels of constructive challenge. The Managing Director of NHS Southwark chairs the Southwark executive safeguarding committee which reports to the integrated governance and clinical commissioning committees. The safeguarding committee meets quarterly giving commissioners the opportunity to consider safeguarding practice across the Borough. The Joint Ofsted/CQC inspection report noted the need for a more strategic approach in the reporting framework to the SSCB, with a clearer trail of evidence of audit findings informing service delivery, contributing to planning and consequent commissioning activity. This includes better assuring the capacity and effectiveness of the Healthy Child Programme in improving public health outcomes for children and young people. All health organisations have good governance structures to monitor safeguarding concerns. Borough and cluster safeguarding leads meet to discuss safeguarding, for example the designated leads meet with the chief nurse for the NHS cluster. The continuation of named and designated roles has been confirmed within the new structural arrangements.

1.3 Health partners are well represented on the Children's Trust Partnership and the Safeguarding Children Board and are well engaged in supporting the planning and delivery of core services for the protection of children. The designated nurse for child protection takes a leading role in safeguarding training and in the practice subgroup. The long-standing, mature professional relationships between all key partner agencies are enhanced by further learning from strategic and operational links with academic institutions and other local authorities outside of the borough. These are aimed towards the further development of evidence based professional practice and more effective ways of working. Overall, health providers in Southwark benefit from having a stable workforce in most areas, with good, well established networks both strategically and operationally. At an operational level there is much sound, active and timely engagement between agencies, particularly evident for those children most in need of protection.

1.4 There has been extensive activity to achieve a joint strategic needs analysis setting out need and demand within the area which is characterised by extremes of prosperity and a wide range of diverse cultural and ethnic communities. Strategic planning is supporting arrangements for the imminent significant changes in the health economy. The public health impact of local arrangements such as the academy school system at secondary level was only starting to be recognised. Clear leadership and a service model which includes the important roles of school nurses in improving health outcomes is needed to inform future commissioning and delivery. The Joint Ofsted/CQC report noted an overall well established and improving commissioning culture with ambitious, realistic and clear approaches to, for example, a revised framework for, and improved multi-disciplinary approach to, early intervention services. Health professionals have taken lead roles in developing safeguarding commissioning.

2. Outcome 1 Involving Users

2.1 The involvement of young people in the development and monitoring of health services in Southwark is adequate. There is no regular way to consult young people on general health matters, though feedback and involvement opportunities are in place in mental health services. CAMHS staff work with young people on a continuous cycle of improvement and use the “You Said, We Did” model to make sure that young people are aware of the changes that they have brought about. There are some good examples of involving young people in specific developments, including the design of Insight, the voluntary sector substance misuse service, and the idea for the Health Huts¹ which came from young people. A young care leaver is a member of the teenage pregnancy board, and young people were members of interviewing panels for the teenage pregnancy co-ordinator and the proposed new young women’s worker. The young people are well supported and paid for these roles. The family nurse partnership includes parents on interview panels for its nurses.

2.2 The Ofsted/CQC report commented very positively on general consultation and engagement with children and young people looked after through Speaker Box and its range of activities impacting across a wide range of issues including health. It had recently been agreed that Speakerbox will start to inspect services but it is too soon for arrangements to be in place. Use of accreditation to the national “You’re Welcome” standards to assure services appropriately focus on meeting the needs of young people is in its early stages in Southwark, with two services having self assessed.

¹ Health huts - in five schools, periodic drop in venues offering personal and relationship advice

2.3 Good attention is paid to recognising the diversity of Southwark's young people; diversity and equality are regarded as core business and form part of staff induction. Staff across the health community know the communities they serve well. Multi cultural awareness training has been provided to increase awareness of specific needs in some service areas in response to serious case review findings. Guidance has been issued to health staff to clarify expectations about unacceptable cultural practices. All safeguarding children training within Health providers includes training on culture and diversity and the possible impact on protecting children. Health partners report good compliance with data collection on ethnicity in RIO electronic records. Staff routinely use independent interpreters rather than family members and translations in the main languages are readily available. All health practitioners spoken to told inspectors that they had good access to interpreting and translation services and examples of this were seen in young people's files. Families of children with disabilities receive tailored on the spot information in a range of key languages which can be printed out by paediatricians in each clinic room.

2.4 A lot of work is done to make information accessible to children and their families, for instance details about medication. Good attention is paid to helping children with disabilities to take part in their annual reviews through a range of communications methods. Aligned to Southwark's communications strategy, a communications expert in the team is able to help children, families and staff including offering Makaton training to staff groups.

2.5 Annual health review checks for young people looked after are carried out by the looked after children's nurse, by paediatricians or 38% by the young persons GP. Although young people are not routinely asked where they would like to have their review or by whom, every effort is made to engage young people over 13 years of age who do not wish to follow the usual route. This has reduced the number of young people refusing their review. Young people looked after hear about their rights and choices in the Speakerbox newsletter but there are currently no written leaflets about health choices for looked after children and care leavers which is a gap they recognise.

2.6 It is recognised that greater attention is needed to preparation and health arrangements for care leavers. Currently there is no leaving care health plan and current care leavers also lacked written information about access to universal services which young people have said is a barrier to them registering with primary care services.

2.7 Though some care leavers did not feel well supported in their transition to leaving care, they told us they valued the support of staff in health services. An action plan is in place and starting to address development needs within the adolescent and aftercare service (AAC), including better recognition of the healthcare needs of young people, better support for those with learning disabilities and improving communication and liaison with healthcare professionals who support young people with significant disabilities.

3. Outcome 2 Consent

3.1 Policies and procedures are in place to ensure consent is requested and taken prior to any treatment of children and young people. This includes procedures to ensure parental or delegated consent is given to healthcare professionals in relation to children and young people who are looked after by the local authority.

3.2 The looked after children's health team reported that timeliness of many initial health assessments could be improved through speedier arrangements for social care staff to share information about consent.

4. Outcome 4 Care and welfare of people who use services

4.1 Health outcomes for children and young people in Southwark are variable, with continued areas of both strong and weak performance. Most Southwark children have good dental health. For children in care for more than a year, dentistry outcome data has also remained strong, with 91% having their teeth checked by the year end. Although showing a slight drop from the previous year, this is above national and statistical neighbours (82% and 86%). Performance monitoring ensured that any gaps in registration with dentists were mitigated by additional sessions provided at the drop in centre towards the end of the year.

4.2 Infant mortality and in particular peri-natal mortality has increased, against regional and national trends. Significantly more children are also affected by obesity at both primary and secondary school entry than in similar boroughs or in England as a whole and the incidence of sexually transmitted diseases is also higher. Girls in Southwark are also less likely than in similar boroughs or nationally to be protected through vaccination for HPV. Protecting children through immunisation remains a challenge, for instance the rate for measles, mumps and rubella in the wider population remains significantly below regional and national averages at both two years (84.5%) and at five years of age. For children in care the immunisation rate is 71%, closer to the national average of 79%. A range of measures have now been identified to track and drive immunisations. Measures have also been identified to boost immunisations amongst looked after children.

4.3 Community paediatricians led and supervised by the designated doctor see nearly all newly looked after children for initial health assessments and draw up the initial health care plan. Trainee doctors working under supervision support the paediatric team's capacity in undertaking assessments. Initial assessments are usually carried out at Sunshine House child development centre. In instances where young people refuse their initial assessment, the designated nurse for looked after children makes significant effort to engage with them and carries out the assessment under the direction of the designated doctor for looked after children. Quality assurance arrangements ensure that initial assessments are of good quality and fully detail the health of the child or young person. Effective use of audit as a quality assurance and monitoring mechanism has identified further areas for some more efficient working practices and improved communications. The team has valuable and dedicated administrative support though they have identified opportunities for better monitoring and tracking of some aspects of health outcomes for looked after children.

4.4 The timeliness of initial health assessments and corresponding health plans is impacted on by the high throughput of children entering the care system together with lack of fully supportive technology to alert health staff promptly. As a result, in the past three months only 20% had been completed within four weeks though most were completed fairly soon afterwards. Arrangements need to ensure the looked after health team are promptly advised of all children coming into care or changing their care placement.

4.5 The designated doctor and nurse for looked after children provide good support to ensure health assessments and plans are as up to date as possible, delivered and monitored. Performance management and reporting contributes to 93% of looked after children having their health assessment and plan reviewed on an annual basis. All looked after children have access to a GP. Currently, inconsistency of practice between general practitioners who carry out most of the review assessments can impact adversely on their quality. Proposals for recommissioning a dedicated service are under consideration.

4.6 Most looked after children and young people have very good access to health services. Community paediatricians provide specialist clinics and there are also dedicated staff and fast track access to speech and language therapy (SALT), to Insight, the young people's drug and alcohol service and to CAMHS (Carelink) and its therapies. All of these services also offer regular drop in arrangements for looked after young people. A multi agency audit in 2010 identified the need for better recognition of the support needs of young women who are looked after. Progress is being made in strengthening targeted assessment and support starting at 13 plus with a new screening tool. It is too early to see outcomes as a new young women's support worker post is being recruited to, to support these young women, in addition to the looked after children nurse who is in post since the audit.

4.7 There are very good and highly effective arrangements to meet the emotional health needs of most looked after children and young people and to support carers through referral to Carelink. This specialist looked after children CAMH service has recently been extended to support young people up to 18 years of age. Most referrals to the multi-disciplinary team are triaged by a panel including a lead clinician. Individual forensic assessments are commissioned where required. Furthermore, the Maudsley is developing additional capacity for forensic intensive interventions, which will be of particular benefit to young people within the youth offending service. The Carelink team continue to work with known young people up until they are 18, as well as young people who are out of Borough, where appropriate. Young people can self refer back into Carelink once discharged. All young people in the care system are assessed through completion of the strengths and difficulties questionnaire (SDQ) all of which are reviewed by Carelink to help identify any concerns. The emotional health score derived from SDQs rose (worsened) very slightly between 2009/10 (12.2) to (14.2) in 2010/11, slightly higher than similar neighbours. Where the SDQ indicates concerns, a more specialist assessment process and specialist consultation is in place to better identify issues. Referrals are then made to specialists, for instance for developmental assessment where needed.

4.8 Teenage mothers-to-be have timely access to good support from specialist teenage pregnancy midwives. Ante natal clinics for young people are held regularly and extended appointments are offered to women who require more time. All women receive a home visit one day after discharge and further visits where necessary for vulnerable women. The local Family Nurse Partnership effectively supports some of the most vulnerable young families, and this also contributes to the high breastfeeding rates. This service demonstrates very positive outcomes for mums and babies, including an example inspectors saw of a personalised service which supported a young care leaver throughout her pregnancy, post natally and in establishing on going successful family life. Parents told us about the excellent work of children's centres with the health visiting teams, and especially how they were helped to become part of local communities. Services to support young dads and dads to be are under developed. Young mums and dads can be supported at Children's Centres, or through Connexions linking to the pregnancy advisor but there is a gap in specific service or programmes to support young dads and dads to be and develop their parenting skills.

4.9 Rates of teenage pregnancies and terminations in Southwark remain relatively high. Given the local challenges, key aspects of the Healthy Child programme and targeted preventative services for young people are under developed. Significant progress has been made, with 15.6% per year reduction in the total number of teenage pregnancies since 2009, to a rate of 53.4 per 1000 relevant population. However, this rate is still well above the national and Inner London average rates. Conceptions amongst under 16 year olds remain an area for significant concern. The rate of 12.9 per 1000 is the worst in London and seventh worst in the country and 76% of these conceptions resulted in termination. Post -termination support has been offered to all under 19s for the past 18 months. Partners have increased their knowledge and understanding about teenage pregnancy amongst looked after young women, most notably through effective audit of the records of 10 pregnancies in 2010 that continued to birth. Seven pregnancies continued to birth in 2011 and it is reported that improved access to advice supported more young women in deciding not to continue with their pregnancy.

4.10 Changes to arrangements for leadership and delivery of the teenage pregnancy strategy include location within the youth service. However, partnerships which have recognised outcomes elsewhere, such as the C card scheme, outreach services, seven day access to CASH and cooperative arrangements between CASH services and school nursing have not been developed in Southwark. The public health impact of secondary schools' independence through academy status has received insufficient attention. Some young people in Southwark schools can access personal, sexual and relationship education and support (SRE), but coverage is patchy and the school nursing role in SRE is very limited in part due to capacity and in part due to the new health and education relationship. Three secondary schools and two pupil referral units have taken up "health hut" partnerships which provide a periodic drop- in service for pupils. Immediate evaluations show their support has been very well received by young people though it is too early to show measurable outcomes. A monthly health hut was due to start in the youth offending service and the probation service had recently been included in a sexual health promotion activity.

4.11 Contraception and sexual health services (CASH) are adequate but insufficiently targeted considering local health challenges. Young people including those who are looked after, access the five CASH services or Brook, including a weekly male only clinic at St Thomas's hospital. Condoms are widely offered through the youth service and other services, otherwise young people are referred to the statutory services which have scope for wider opening hours and an increase to seven day access. A majority of pharmacies in the Borough offer emergency contraception and four pharmacies are now also offering ongoing oral contraception at the same time. CASH and contraception providers use a proforma to identify safeguarding issues and ensure compliance with guidance. The incidence of chlamydia is very high in Southwark, though the borough is in the top five nationally for meeting national screening targets.

4.12 Specialist health visitors provide very good and valued support to children in a range of targeted services. However the universal health visiting service is currently constrained in delivery of the *Healthy Child* programme and provision of an effective safety net. Despite the use of skill mix, caseloads are described as extremely stretched and in some teams caseloads are held corporately and focus on priorities. Funding has recently been agreed to support new recruitment to strengthen teams' capacity. We heard that the case load weighting system was affected by significant staff turnover. In parts of the borough routine health visitor antenatal checks are inconsistent except where there are child protection concerns; recent audit found only 30% of expected appointments were completed. Only the most vulnerable families receive the full offer of health visitor perinatal checks at home and the service struggles to visit all mothers within the 10-14 day target especially where babies are born out of borough. The health visiting service works hard to proactively follow up women who do not attend other health appointments, though the extent to which they are informed by other professionals is variable. Arrangements to transfer families from the health visiting service to the school nursing service prioritise families known to be vulnerable.

4.13 The school nursing service provides an adequate service overall but its place in improving outcomes through leadership of delivery of the *Healthy Child* programme for school age children is under developed. Depletion of the teams' staffing, the impact of capacity changes in other services making additional demands on their time, the high level of child protection work and difficulties in establishing relationships across high schools all affect the service's capacity. School nurses prioritise safeguarding activities including attendance and reports for core groups which take up an extensive proportion of time. An increased proportion of their time is also now spent in supporting the needs of children with disabilities since the reduction in capacity in the special needs nursing service. These priorities severely impact on delivery of wider health promotion activities, their contribution to transition planning and ability to become familiar with children in schools on their patches. School nurses face other barriers in delivering their role, in for instance, personal and social education, which need to be strategically addressed. The public health significance of their role is starting to be recognised strategically by PCT commissioners but no plans are yet in place.

4.14 Children and their families have access to a range of effective child and adolescent mental health services. Children with urgent needs are prioritised through the daily triage arrangements though other children have to wait up to four months which is longer than acceptable to be seen for an initial assessment. Most professionals reported good communications and liaison with CAMHS and adult mental health, though GPs had more variable experiences. A parental mental health service is funded by the Children's Services early intervention budget and delivered by South London and Maudsley NHS Foundation Trust (SLAM). A range of effective targeted services support families, including a specialist parental mental health service for parents under distress with children under five, and a weekly CAMHS and adult services parent and toddler drop in, which is recommended good practice.

4.15 Specialist CAMHS offer a flexible service and will accept direct referrals from most professionals working with children and young people. A number of core CAMHS staff provide services across Southwark including those that work as part of the multi disciplinary team based in primary care. Young people who are acutely unwell are very well supported where possible at home, through the young people's service operating a five day week service. In patient care is available locally if required. Of note is the policy of the SLAM not to admit young people under 18 onto an adult ward. CAMHS measure the effectiveness of their services through outcome scores which demonstrate that the service makes a positive difference to the lives of children and young people.

4.16 Purpose built, Sunshine House is a highly valued children's health and development resource offering integrated community health and social care services, with a particular focus on children with a disability and those with additional vulnerabilities. As a co-located base, it facilitates more effective communication and service co-ordination around the child and family, leading to earlier diagnoses and provision of support for positive outcomes for children. The 'team around the child' approach is increasingly coordinating therapy appointments therefore reducing disruption for the child. Health staff are committed to ensuring this co-ordination becomes routine practice, particularly where a child may need multiple invasive clinical interventions.

4.17 Most families have good access to effective therapy services to support children and young people. Most waiting times are reasonable, at about 6-8 weeks for a paediatrician or speech and language assessment. There are concerns that children who attend pupil referral units may miss out on speech and language therapy services as a result of contractual arrangements. Some parents reported that they struggle to gain access to respite services or short breaks, finding thresholds too high within social care funded services for children with disabilities. A good range of services supports children with disabilities. Use of a therapy suite at the child development centre with light sensory rooms is particularly beneficial to children with sensory and/or hearing loss. Specialist dental services support children with disabilities and challenging behaviours. The children with disabilities team accepts self referrals and work towards discharges from the team by enabling self abilities, but will accept re-introductions should there be difficulties.

4.18 Decisions about placements for children with complex health needs are made by the MATCH panel and placements identified through joint working between health and social care disabilities teams. Children with continuing care needs can also access respite in hospitals. There is a specialist end of life care nurse in addition to the single nurse for continuing care; however we heard that children with palliative care needs do not reliably receive the service continuity they should be able to expect. Continuing care nursing is entirely commissioned from agencies and hospices with clinical governance oversight of training and care plans. Personal health budgets are just starting but are not yet available for children.

4.19 Midwives have improved pathways and clear, effective processes in place to identify vulnerabilities in women when they book their pregnancy or subsequently. This co-ordinated approach ensures that delivery and child protection plans are usually made well in advance to safeguard the baby once born. Recent changes to practice to strengthen the identification of risk include greater focus on recording details of fathers and partners and a pre discharge check list. A responsive vulnerable pregnancy midwifery team supports women who require peri-natal mental health support and women who have substance misuse or alcohol problems. A community safeguarding specialist nurse based in the community child protection team attends weekly perinatal safeguarding meetings at KCH and liaises with the HV service to support early intervention.

4.20 A relatively higher number of looked after young people have alcohol or substance misuse problems than in comparative areas and they are much more likely to access early intervention support services. A voluntary sector service, Insight, is commissioned to provide effective specialist prevention and early intervention services for young people up to 24 years. The service's good engagement with young people results in self referrals of 60%. Looked after young people and care leavers have good access through a weekly satellite drop-in and a LGBT group is available. Insight workers share knowledge and promote services through presentations to all social care teams. The leaving care team was recently trained by Insight prior to implementation of an integrated screening tool for teenage pregnancy, youth offending and substance use to help to identify vulnerability and trigger an early referral to relevant services to develop effective early interventions. CASH services have also recently implemented alcohol screening for 13- 18 year olds followed by an offer of referral or brief intervention.

4.21 An increasing range of good services support families where parents have substance misuse problems. Children are also helped through specific work with parents in adult services, for instance the Foundation 66 service women's' group, which constantly assesses parenting capacity.

5. Outcome 6 Co-operating with others

5.1 Partnership working across health, social care and education works well operationally to secure improved outcomes. Where co-location arrangements are in place, these facilitate co-operative and joint working. Co-location of most looked after children's services has recently been achieved at a new purpose built facility with CAMHS located nearby. Sunshine House also adds particular value in supporting children with disabilities, and their joined up working extends into schools including out-borough schools attended by Southwark young people. Through the increasing development of new services, early intervention and preventative services are becoming strengths. Protocols and practice frameworks are being reviewed or put in place to guide multi-agency practice and ensure that service interfaces continue to operate effectively.

5.2 Integrated child support service (ICSS) arrangements involving health specialist and midwifery support provide high quality information and contribute to assessments of unborn children. The team undertake many joint assessments with social workers to move things forward and link looked after children into local services.

5.3 Health partners contribute to and demonstrate the impact of learning from significant incidents and serious case reviews, including from cases which have serious features but which do not meet the threshold for a serious case review. Progress on actions against recommendations from serious case reviews is regularly discussed at named professionals meetings, and at the sub group of the SSCB. Amongst numerous examples of direct results of the lessons learned from serious case reviews, significant changes had been implemented to strengthen safeguards in midwifery.

5.4 The Carelink team work with foster carers to support them if a young person is not in a stable placement or if a young person refuses to engage with their service. This helps the foster carer to understand and manage behaviours that may have contributed to placement breakdown.

5.5 Arrangements to support transitions are variable. Health and social care partners recognise that improvements are needed to better support young people and their families at some important transition times such as moving from children's services, leaving care and young offenders release from custody. It is also recognised that for children with enduring, complex needs, thorough and consistent transition planning needs to start at an earlier stage and that arrangements also need to better support young people falling outside adult service criteria. A new integrated health and social care transitions team is being established to improve the consistency of arrangements.

5.6 For young children with disabilities, transition arrangements are good. Very good arrangements and partnership working supports the discharge of early birth babies or those with complex needs through multi disciplinary discharge planning meetings, a specialist early birth clinic at GSTFT and at KCH a dedicated paediatrician. There is good support for home to nursery transitions, including multi agency TAC meetings. Parents' choices of school at the primary to secondary transition are helped by information sessions and preparations involving the children start the summer before the move. The planning and review process for older children with disabilities starts at 14 years and from 16 years planning starts to include equipment and support for college or university where appropriate. For children in special schools with school nurses on site, transitions panel arrangements work well but the local school's system and school nursing pressures mean that other children lack the support and input of school nurses in the transition panel arrangements. Where young people meet criteria for adult services, transition into adult mental health services is timely and well planned. From 16 years, quarterly multi agency transition meetings start to discuss the future support needs of young people. Staff reported flexibility with the age of transition for young people with learning disabilities, to ensure the handover from adult services happens at the appropriate time and in a way which meets the individual's needs. However there is a lack of services and support for young people whose needs do not meet adult services thresholds.

5.7 Partnerships to improve health outcomes for young people who offend are adequate and improving. Co operation and liaison between the youth offending and looked after children teams had significantly strengthened recently. The looked after team reported that health assessments are increasingly being drawn up to support the health needs of young offenders. However there is a lack of a clear discharge pathway to ensure health input to the pre discharge planning for young offenders, and health needs can be overlooked. Young offenders can be linked into the Insight drug and alcohol service before release, which can be part of their order. Young offenders can also access Insight at a weekly drop in session at the looked after children centre. A CAMHS worker is located within the youth offending service; partners experienced that where a young person is already known to CAMHS support is relatively easy to engage. Where the young person is not previously known partners find it less easy to secure engagement.

5.8 There are good partnership arrangements between the main A&E services at KCH and other services across Southwark, supporting early identification and support to vulnerable children and young people. A&E departments are liaising about young people in relation to gang activity, contributing to the local partnership priority of making Southwark a safer place to live. Young people up to the age of 18 who attend A&E following an incident of self harm are supported very well by CAMHS. Any young person under 16 is admitted to the paediatric ward for a short period in line with NICE guidance. Older adolescents are either admitted to the A&E short stay unit or discharged following consultation with CAMHS but followed up subsequently. Regular A&E multi agency safeguarding meetings are well attended by health and social care partners. The named nurse from SLAM attends the meetings as well as representatives from substance misuse services and key teams within the acute trusts. These meetings ensure that families are receiving appropriate support through either Team around the Child or the involvement of social care. Attendance of pregnant women at A&E is routinely notified to maternity services enabling the midwife to provide appropriate follow up contact. Weekly multi disciplinary vulnerable pregnancy meetings enable social care and midwives to meet to discuss and monitor referrals. This co-ordinated approach ensures that child protection plans are usually made well in advance to safeguard the baby once born.

5.9 Not all GP practices have a co-located health visitor, but where the arrangements are in place, they are found to be particularly effective in supporting vulnerable families. Regular structured meetings between general practitioners and health visitors take place in some parts of the Borough and contribute to primary care safeguarding arrangements for children. There is scope to develop and extend these arrangements, as identified in the safeguarding work plan.

5.10 Good and increasing awareness on the potential impact of parents' mental health on children is well supported by the SLAM approach to 'Think Family'. The Trust uses a child need and risk form that is completed for any child that belongs to the family of the adult service user, as well as for any child with whom they have contact. All requests to attend case conferences are well considered to ensure appropriate attendance and information is provided. A liaison post is highly effective and visible in bridging understanding and promoting work between adult and children's mental health services and safeguarding partners. Many examples were given where adult mental health staff had completed a CAF or attended a team around the child meeting to ensure that the needs of the family were discussed across all agencies, including housing and education.

5.11 Foster carers are well supported by the looked after children health team, children with disabilities team and Carelink services. Training for foster carers and adoption parents is flexible and highly valued, with a combination of rolling programmes such as on drugs and alcohol, training on general topics and guidance specific to a child. Recognising the impact of adolescence, all foster carers are invited to a seminar and receive a pack when a young person in their care reaches 13 years of age. The designated nurse for looked after children provides health promotion support to help foster carers keep children and young people healthy and has recently piloted a successful two day SRE course. Specialist health staff contribute to attachment training for foster and adoptive parents to strengthen their knowledge and approaches to caring for children with emotional health or behavioural difficulties. Further good examples of support are the Carelink under 12's and the teenage changes programmes which are run according to demand.

5.12 Carelink and the children with disabilities team (CWD) provide good support to the high number of children placed outside Southwark, even in distant placements. They will visit to liaise, help in assessment and provide equipment. Carelink also provides services for all care leavers and adopted children. Young people from other local authority areas who are fostered by Southwark families are supported on the same basis as Southwark children, through the generic CAMHS and CWD services.

5.13 A good and growing range of services support children and young people on the edge of care, offering effective interventions and an alternative to care for a significant number of families. A highly regarded less intensive parenting service supported 260 families last year, delivering good quality group programmes and individual parenting programmes within the home environment. Families who need support services are being identified at an earlier stage, improving outcomes for children. The impressively skilled intensive family focus team accepts referrals about complex families from family intervention, youth offending, and victim support via CAF or directly. The unique highly intensive work which can support 36 families at one time is dovetailed with community services over 18 -24 months. As a result they have improved outcomes for children in hard to engage families who have often slipped through universal services and are coping with long standing health and lifestyle challenges. The service is imminently to be enhanced by the addition of a family therapy team aimed at reducing youth offending and children entering care. The team's work identifies barriers and opportunities for partners to improve systems and processes to pick up those who are hard to engage, such as families not attending appointments without follow up which can be due to administrative hoops such as the need to confirm appointments.

5.14 Specialist health staff contribute to new CAF triage arrangements in the referral and assessment service. From late 2011, the common assessment framework (CAF) became the single referral tool for social care service access and is increasingly the access tool for health services including for children with disabilities. Many health staff have received CAF training, some training was still to be delivered. Community staff were positive about CAF in instigating a team around the child rather than waiting for social care responses. Within schools, school nursing staff often work with the special needs co-ordinators who generally instigate the CAF. Referrals from schools are passed to an early help panel for access to additional services. GPs reported their involvement with CAF was variable but increasing. Inspectors heard that the use of the CAF form has also improved the pathway for maternity services referral of late bookers and the subsequent responses of social care. Most teams received feedback from social care on receipt of CAFs. Clear processes are in place to escalate concerns in the case of professional disagreements between health practitioners and colleagues within social care.

5.15 All health disciplines inspectors met had experience of making child protection referrals and were clear about their responsibility to follow up referrals. Pathways are not yet fully robust in ensuring referrals are always acknowledged though health staff reported this is now more consistent. Smaller specialist teams and services in the voluntary sector are least likely to be kept in the loop after making a referral but work was underway to strengthen follow up arrangements to referrals to children's social care.

5.16 Health professionals give priority to attending case conferences and core group meetings. They reported that they are generally invited to meetings, especially to the first meeting, though this is less consistent subsequently. Health partners are well engaged in contributing to child protection plans and gave examples where their input has secured improved outcomes.

6. Outcome 7 Safeguarding

6.1 There is good, effective leadership across the health community from the designated doctor and the designated nurse for safeguarding. They facilitate meetings of named professionals across provider services, provide training and support to health professionals and are starting to monitor training levels at provider services. The designated nurse is highly experienced and skilled, is employed full time within the commissioning arm of the PCT and is diligent in undertaking the designated role and responsibilities. Clinical and non-clinical staff across the health community are aware of their safeguarding responsibilities. Health staff across provider services are aware of risk identification and where to seek advice and guidance if they have concerns about a child. There are also clear pathways across services to follow up non-attendance at health appointments.

6.2 The designated nurse is a member of the Southwark safeguarding children's board, a professional advisor to the main Southwark safeguarding board and attends the Children's Trust Board meetings. She is line managed with regular supervision by the assistant director for commissioning and also has peer supervision from designated nurses across the cluster and meets regularly with the NHS South East London Cluster executive safeguarding lead. Named nurses in provider organisations are appropriately supervised by the designated nurse. She also meets regularly with the named professionals across Southwark to maintain a strategic overview on safeguarding practice across health services within the Borough.

6.3 With one exception, named staff for safeguarding are in place across the provider organisations and are providing good information, supervision and support to health staff. They have sufficient time to undertake their roles and have access to supervision and support. They also attend London and national forums for named professionals.

6.4 The arrangements for the named professionals for safeguarding children within the GSTFT are good and being further strengthened through more formalised arrangements. Established systems including a single point of contact ensure that the named professionals are aware of any safeguarding referrals to social care. The safeguarding children team are accessible to give health practitioners immediate support.

6.5 The arrangements for the line management, supervision and training of the named professionals for safeguarding children within the South London and Maudsley NHS Foundation Trust are good. The named nurse for safeguarding children is directly line managed by the trust board executive safeguarding lead which is good practice. Good monitoring arrangements are in place to ensure that trust staff consider and respond to all requests for attendance at child protection conferences and these include making sure that reports are completed and sent.

6.6 Arrangements for designated professionals for looked after children are good though stretched. They provide effective leadership across the area and are influential and active in promoting the interests of looked after children. However, the limited time of one session per week allocated to the designated doctor role presents challenges in discharging continuously the full range of strategic and operational responsibilities. The medical advisor for fostering and adoption has 8 sessions allocated weekly. The designated nurse for looked after children is fairly new in post but starting to make a real impact after a gap in the post being filled. Although this is a full time role, capacity is also very stretched due to the overall high number of looked after children, the turnover of children entering and leaving care and high numbers of children with complex needs. The team have dedicated admin support though there are opportunities for better monitoring and tracking of some aspects of health outcomes. Arrangements for their line management and access to supervision and training meet the requirements of Working Together 2010 and the Intercollegiate Guidance 2010.

6.7 Health partners are highly committed to partnership working to ensure that children and young people in Southwark are safe and well protected. Attendance at child protection meetings by almost all health practitioners is given high priority and is good and increasingly monitored by the provider organisations as part of their board assurance framework. The record of GPs attendance at these meetings is however patchy due to conflicts in the timing of meetings and surgeries. GPs reported that some teams liaised helpfully in scheduling meetings but recognised that some meetings need to be held at short notice which would clash with surgery times.

6.8 At a strategic level, the role of general practitioners in safeguarding is well represented in the shadow commissioning arrangements through a GP safeguarding lead who is a member of the clinical commissioning group, the Children's Trust Board and the SSCB and shares information with colleagues. Operationally, GP practices have identified safeguarding leads though arrangements including role descriptions, supervision and monitoring are not yet in place. The designated nurse offers flexible arrangements to deliver level 2 safeguarding training and the website advertises level 3. Clarification of safeguarding training expectations for GPs was an outstanding issue from the 2010 Safeguarding Improvement Team review. Inspectors heard that GPs are increasingly taking up child protection training opportunities at an appropriate level via the SSCB. Compliance data was starting to be collated by the designated nurse, but no data had yet been presented and it was too soon to be available for the inspection.

6.9 The safeguarding lead GPs inspectors met are aware of their safeguarding responsibilities, make alerts and write reports. Recently established sector arrangements for GPs are helping to establish regular meeting opportunities to share experience. E-learning packages, guidance and policies as well as template reports are available on the local intranet to support GPs in writing reports for child protection conferences. GPs in Southwark have systems to identify and flag vulnerable children, young people and their families but recognised that their systems for flagging and coding are not consistent. The delivery and monitoring of safeguarding training for other primary care services including dentistry, pharmacy and optometry was being delivered at NHS South East London sector level. The extent of borough compliance was not known to local commissioners.

6.10 Health partners are well engaged in the domestic violence agenda across Southwark including full engagement in multi-agency arrangements (MARAC) to manage serious domestic violence cases. Domestic violence is a key training priority in Southwark and inspectors found generally good understanding amongst health professionals. General Practitioners recent training on domestic violence had had a significant impact in awareness raising though there is more to do to ensure GPs responses to domestic violence concerns are consistent. GPs inspectors met had increased appreciation about the impact on children but were unclear how they should respond across the range of circumstances. Following a review of domestic abuse arrangements in the borough, services have recently been rationalised and contracted from a new provider to meet the therapeutic and support needs of adults and children. There is refuge provision in the borough, however, this does not accept the teenage sons of women, and some young males are placed in bed and breakfast or supported accommodation which is not best child centred practice.

6.11 Good arrangements are in place to ensure child protection medicals are carried out quickly and by appropriately trained staff. Acute medicals following allegations of sexual abuse are carried out through the CAMHS service at the local Haven facility at Kings College Hospital. The Sunshine House children's health centre also has good, specialist facilities to follow up the health needs of these children or to undertake child protection medicals which are outside the forensic timeline. Good arrangements are in place to address the physical and emotional needs of victims of child sexual abuse, including a sexual abuse treatment service.

6.12 An effective Child Death Overview Panel (CDOP) which covers Southwark and Lambeth is established as a sub group of the local Safeguarding Children Boards. It is appropriately constituted, chaired by a consultant with experience in public health and well attended. As a result of the high volume of 70 -80 cases annually, the CDOP has recently streamlined arrangements for reporting child deaths. The panel is functioning more efficiently and is beginning to identify further emergent trends, for instance more attention was starting to be paid to safe sleeping though no specific campaign was in place. The CDOP has a good profile with frontline health staff, and there is evidence that lessons learned from local and national incidents are improving frontline practice with the CDOP is playing its role in driving these improvements.

6.13 Southwark residents predominantly access acute hospital services at Guy's and St Thomas' NHS Foundation Trust (GSTFT) and Kings College Hospital NHS Foundation Trust (KCH). The hospital based A&E departments operate effective systems to highlight children they identify as vulnerable or repeat attendees. They inform GPs, health visitors, school nurses and social workers that a child has attended the department. Staff spoken to knew how to make a referral, were aware of thresholds, knew who to talk to for information, advice, clarification and support and did not raise concerns about the process. Paediatric liaison health visitors in post in accident and emergency departments provide support, specialist safeguarding advice, training and liaison to acute and community providers regarding vulnerable children.

6.14 Neither acute hospital has IT arrangements to ensure comprehensive information is available to all including a Trust-wide flagging system across their data bases or fully comprehensive arrangements to check child protection lists. The hospitals have arrangements for asking suitable questions to ascertain social worker involvement. At KCH the maternity unit has a separate records system on which vulnerable women are flagged but this cannot link into their wider systems. KCH had now developed a Trust-wide database but the interface to its systems had not yet been developed. In the meantime the Trust has agreed to accept child protection lists from local Boroughs and upload to the emergency department system from June 2012.

6.15 The 24 hour Lister GP walk-in centre which inspectors visited lacks a computerised or paper system to identify if a child attending is on a child protection plan and also lacks other systematic arrangements to identify children who are vulnerable and their families or to share information. Inspectors later heard that a paper based system for checks had been agreed and was to be implemented swiftly and a monitoring action plan is in place. An agreement has been made that the walk in Centre will receive Southwark's list of child protection children and ensure these are flagged on the electronic records.

6.16 Services to meet the needs of children and young people who self harm are good. Appropriate protocols are in place for young people up to the age of 18 attending St Thomas' or KCH to be assessed by CAMHS staff. There is high awareness by health providers of the safeguarding issues linked with domestic abuse. St Thomas' Hospital has a specialist service which provides for women and girls experiencing violence with referral pathways from maternity and sexual health services. Staff reported good links with social workers. Specialist youth services are in place at the acute hospital trusts to engage young people who attend following incidents of violence with good continued support after discharge and referral to other organisations. This is good practice.

6.17 Health professionals were aware of the role of the Local Authority Designated Officer (LADO) and how to notify them of any concerns and allegations made against staff working with children. Notifications to the Southwark LADO are low, but the major health providers are located in Lambeth.

7. Outcome 11 Safety, availability and suitability of equipment

7.1 A dedicated staff team and very good partnership arrangements are in place to provide timely access to equipment to support children with disabilities. All physio and occupational therapists are trained as assessors for simple equipment from the joint equipment store. Once assessed at Sunshine House, health therapists can also access the education budget to provide equipment. Therapists make good use of new technology to improve children's quality of life and undertake fund raising and joint charitable applications for very expensive equipment that otherwise would not be available. There are arrangements to ensure children's individual health needs are supported. Individual therapists and nurses train carers and families to best support children with complex needs at home whilst the continuing care nurse and school nurses train in schools, for transport staff and for others who support children's health needs.

7.2 Security systems are in place within A&E departments and children's and maternity wards and no security issues were raised. During the re-development work at St Thomas Hospital appropriate arrangements have been made to ensure patient safety and work staff do not need to access patient areas.

7.3 In visiting the Lister walk in centre inspectors found that considering the number of children who the centre, facilities are only basic, with no designated children or young persons waiting area, no play equipment and lack of consideration for the needs of nursing mothers. The PCT has now put into place an action plan including consideration of environmental improvements.

8. Outcome 12 Staffing recruitment

8.1 Good training in the health needs of looked after children and how to carry out effective health assessments is carried out with health visitors and school nurses by the designated nurse for looked after children. The designated nurse also meets with any new public health nurse as part of their induction. This helps to ensure that practitioners carrying out health reviews are competent.

8.2 Safer recruitment processes are in place across provider organisations. Criminal Record Bureau (CRB) checks are completed for all new staff in provider units. All health professionals in post prior to 2002 have had a CRB check and arrangements are being reviewed to ensure the robustness of the process to renew CRB checks for staff every three years.

9. Outcome 13 Staffing numbers

9.1 Children with a child protection plan are accorded top priority on health visitor and school nurse caseloads. However, staff turnover with gaps in replacement hours and the high numbers of children on protection plans has meant less time is available for preventative work with children and families with lower levels of need. In health visiting for example, one team covering a large population of families has reduced from four full time health visitors to one, with two part time staff. Vacancies are sometimes covered by agency or temporary staff or otherwise managed by rotas for clinics and prioritising and sharing of child protection and children in need cases. Gaps in the capacity of health visitors to fully implement the requirements of the Healthy Child Programme are acknowledged and funding secured to implement workforce plans to enhance service delivery.

9.2 School nurse provision is thinly stretched in several areas, resulting in a reduction in their capacity to undertake the health promotion work which is particularly important for improving challenging local health outcomes. The role, capacity and skill mix of the school nurse service and its place in partnerships supporting children urgently require further review.

9.3 Dedicated paediatric accident and emergency departments are in place at both St Thomas' Hospital and Kings College Hospital, with appropriately trained specialist paediatric staff and a high level of child protection training, which is good practice. However staff at the 24 hour GP-led Lister walk in centre (WIC) had undertaken appropriate safeguarding training no member of staff had paediatric training which is unacceptable given the large number of children attending the centre. There had also been no basic training on recognition of the acutely unwell child for the front line administration staff who during peak periods may have closest prolonged monitoring of children and young people awaiting their appointments.

10. Outcome 14 Staffing support

10.1 Almost all named and designated professionals are in post and provide guidance, support and child protection supervision to health staff. One named post was being imminently recruited to. Safeguarding policies are accessible to health staff through the hospital and PCT intranet systems, each of which has a dedicated safeguarding site. Induction arrangements for provider staff include safeguarding awareness. Ongoing training programmes are available to maintain training levels and are adapted to local circumstances. Child protection training includes learning from serious case reviews and management reviews that are relevant to health partners, for example improving maternity discharge arrangements and following up missed antenatal appointments.

10.2 An appropriate percentage of health staff in most provider services have up to date child protection training relevant to their role. SLAM and GSTFT acute services have achieved very strong training compliance. GSTFT provider services are making good progress in ensuring full compliance amongst staff transferred into the Trust in 2011. Compliance with safeguarding training commensurate with roles at KCH has remained unacceptably low, especially amongst clinical paediatric staff. As at May 2012 KCH achieved compliance at level 1 through use of a payslip leaflet but compliance with training at levels 2 and 3 relevant to staff roles was poor, with 40% trained at level 2 and 59% at level 3. A recovery plan overseen by the PCT is in place to address the deficits within three months. Implementation of a new system has given the Trust the ability to identify on a named individual basis those who are not compliant with training and performance management arrangements are now in place.

10.3 Safeguarding supervision arrangements are mostly good; formal safeguarding supervision policies are in place in all health services, with specified frequencies between fortnightly and three monthly. In some teams group supervision is also used to share learning from specific cases. Good progress had been made in implementing risk based supervision across midwifery services. However, compliance with policies on supervision frequency is variable between services, for instance a recent audit of school nursing and health visiting supervision revealed that all staff received supervision but less than half met the frequency. Inspectors heard that arrangements are affected by capacity, management staffing turnover, and locations where proximity to a nurse manager can be an issue. This means that practitioners receive insufficient support given the high caseloads and complex challenges in the local area. Staff in all services, including all adult services, are able to access day to day safeguarding advice and guidance and support from lead professionals and named nurses and doctors via an on call mobile phone. They find this helpful but this is not a sufficient replacement for supervision.

11. Outcome 16 Audit and monitoring

11.1 The London-wide Safeguarding Improvement Team (SIT) reviewed arrangements for safeguarding in the Southwark health partnership in October 2010. The report identified strong commitment and much good practice whilst also making several recommendations for improvement which formed an action plan for partners. Recommendations in relation to compliance with safeguarding training expectations and in comprehensive systems for flagging children at risk remained outstanding in one Trust at the time of this inspection.

11.2 Board assurance in safeguarding children within the NHS Southwark PCT, South London and Maudsley NHS Foundation Trust, the Guy's and St Thomas' NHS Foundation Trust and Kings College Hospital Foundation Trust is of good quality, generally effective, and supported well through clear governance structures. The Southwark safeguarding executive committee formally reports to the Southwark Safeguarding Children Board (SSCB) through the section 11 annual report. In particular, the GSTFT and SLAM Trusts have an impressive assurance framework for safeguarding children.

11.3 Governance arrangements for safeguarding practice are good. Trust boards receive their organisation's safeguarding annual report and additional update reports and report in turn to the commissioning executive safeguarding committee. Inspectors saw an example where safeguarding risks were escalated to the trust board. Performance against the plan to achieve compliance with safeguarding training requirements is being monitored at KCH safeguarding children meetings and at the Borough safeguarding executive meetings.

11.4 Health partners use a range of IT systems, though RIO is the most widely used and enables community staff such as health visitors and district nurses to access wider records, for instance therapists'. Appropriate health staff increasingly have access to the social care system, with work around solutions in multi disciplinary teams. The disparate systems can present problems in ensuring information is uploaded between systems, for instance the acute trust data base. Inspectors heard of some difficulties for social care staff in accessing timely CAMHS information as a result of their different systems.

11.5 Audits are well used to better understand performance, or test effectiveness or compliance in many aspects of the health partnership. A range of improvements in service have subsequently been put into place, for instance support for looked after young women in relation to pregnancy and prevention have improved as a result of the audit in early 2010 and action plan which was monitored by the looked after children's health steering group.

11.6 The designated doctor for looked after children reports annually in an extensive report to the Corporate Parenting Board. Health service development for looked after children is driven by an action plan overseen by a health steering group. The group's successes include the increased focus on health outcomes in the commissioning of services for looked after children. More specific outcomes and target dates would further enhance the effectiveness of the action planning and better assure prompt delivery of the priorities and ambitions.

12. Outcome 20 Notification of other incidents

12.1 Provider services have suitable arrangements in place to ensure notifications are reported to the relevant agencies.

13. Outcome 21 Records

13.1 Within SLAM the named nurse had worked with adult mental health services to review and amend the child risk screening tool, which was about to be implemented on Trust electronic records.

14. Recommendations

Immediately:

Southwark NHS Primary Care Trust, Guy's and St Thomas' NHS Foundation Trust and Kings College Hospital NHS Foundation Trust to ensure robust arrangements are in place to identify and communicate concerns about children who are at risk or in need of protection, and are effective.

Within 3 months (from report)

Southwark NHS Primary Care Trust and Guy's and St Thomas' NHS Foundation Trust to ensure sufficient capacity to deliver in full the healthy child programme, including take up of the child immunisation programme, is maximised, and the commissioned core offer in school nursing is delivered in full.

Southwark NHS Primary Care Trust and Guy's and St Thomas' NHS Foundation Trust to ensure that safeguarding supervision for community health practitioners is in place in compliance with *Working Together* guidance.

Southwark NHS Primary Care Trust and Guy's and St Thomas' NHS Foundation Trust to ensure sufficient capacity to deliver in full the strategic and operational aspects of the role of designated doctor for looked after children.

Southwark NHS Primary Care Trust and Guy's and St Thomas' NHS Foundation Trust to ensure that primary care staff with access to children undertake safeguarding training commensurate with their roles, and that compliance is monitored.

Southwark NHS Primary Care Trust to review the commissioning and provision of urgent care for children attending walk in centres and address the skills mix of nursing staff to ensure children have access to specialist care.

Within six months:

Southwark NHS Primary Care Trust and partner agencies to ensure sufficient services are in place that support men in developing their parenting skills and to ensure that their violent behaviour within domestic abuse situations are more effectively addressed.

Southwark NHS Primary Care Trust, Guy's and St Thomas' NHS Foundation Trust, the local authority and the youth offending service to ensure that young people's health needs are fully addressed in preparation for leaving care, including the consistent provision of summary health plans.

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.