Review of health services for Children Looked After and Safeguarding in Brighton and Hove

Children Looked After and Safeguarding
The role of health services in Brighton and Hove

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Provider services included:	Sussex Community NHS Foundation Trust Brighton and Sussex University Hospitals NHS Trust Sussex Partnership NHS Foundation Trust Ru-ok? Pavilions
CCGs included:	NHS Brighton and Hove CCG
NHS England area:	South East
CQC region:	South East
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Brighton and Hove. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Brighton and Hove, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
    - the role of healthcare providers and commissioners.
    - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
    - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2018.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 46 children and young people.

Context of the review

The 2019 Child and Maternal Health Profile (ChiMat) profile provides a snapshot of child health in Brighton and Hove. Children and young people under the age of 20 years make up 20.9% of the population of Brighton and Hove with 26.6% of school age children being from an ethnic minority group.

On the whole, the health and wellbeing of children in Brighton and Hove is mixed compared with the England average.

Commissioning and planning of most health services for children were carried out by Brighton and Hove CCG.

Commissioning arrangements for looked-after children's health were the responsibility of Brighton and Hove CCG and the looked-after children's health team.

Designated roles and operational looked-after children's nurses were provided by Sussex Community NHS Foundation Trust (designated doctor looked after children and operational looked after children's nurses) and Brighton and Hove CCG (designated nurse looked after children). At the time of our review, Brighton and Hove was also in the process of implementing a Looked After Child (LAC) assessment one-year pilot involving a clinical psychologist as part of the Initial Health Assessment (IHA) with a focus on Unaccompanied Children Seeking Asylum (UCSA), (funded by The Anna Freud Centre).

Acute hospital services were provided by Brighton and Sussex University Hospitals NHS Trust

Health visitor services were commissioned by Public Health and provided by Sussex Community NHS Foundation Trust

School nurse services were commissioned by Public Health and provided by Sussex Community NHS Foundation Trust

Contraception and sexual health services (CASH) were commissioned by Public Health and provided by Brighton and Sussex University Hospitals NHS Trust

Child substance misuse services were commissioned by Public Health and provided by Ru-ok?

Adult substance misuse services were commissioned by Public Health and provided by Pavilions.

Child and Adolescent Mental Health Services (CAMHS) were commissioned by the CCG and provided by Sussex Partnership NHS Foundation Trust. CAMHS also provided mental health consultation and advice to the Local Authority LAC team by Clinical Psychologists.

Children and young people's emotional wellbeing services (mild to moderate mental health) were commissioned by the CCG for the Children and Young People's Community Wellbeing Service (up to age 25 years), and provided by Here. The equivalent service in schools and colleges (Schools Wellbeing Service) was jointly commissioned by the CCG, Public Health and Local Authority and provided by the Local Authority.

Specialist facilities for Mental Health Services (Tier four, inpatient services) were commissioned by NHS England and are provided by multiple providers, although locally this included Sussex Partnership NHS Foundation Trust at Chalkhill Hospital in Haywards Heath, West Sussex.

Adult mental health services were provided by Sussex Partnership NHS Foundation Trust.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from one looked after young person. They told us;

"My looked after nurse checks on me at least a couple of times every year. I'm happy to have my health checks done. They are done at my foster house and I am seen alone which is nice. I've only ever had to see two nurses in all the time I have been in care and I like that."

They went on to tell us;

"As I have got older the nurse has treated me much more like an adult. When I needed advice about safe sex they were there for me. It's an awkward kind of subject to talk about but I am OK with that because they always give me good advice."

When asked about their relationship with the children in care health team they told us*;*

"I really like my nurse. She asks about me and has advised and helped me too. When I was in a relationship that wasn't very nice she gave me advice that was really useful. She has also offered me sexual health advice that makes sure I keep myself safe. There is nothing that I can think of that they are doing wrong."

We spoke with the manager of a children's home. They told us;

"I have a very positive relationship with the looked after children's team (Children in Care Health Team). We had a child staying with us that was struggling with sleeping through the night. This was also affecting their days at school as they were disruptive. We had a robust plan in place to help them, but they were still not sleeping."

"I spoke with the looked after children's nurse and they made a referral to a paediatrician and offered me some advice. As a result, the child was seen by a paediatrician and prescribed a low dose of medication to help them sleep. The result has been massive. The school has commented on how much better they are doing in school and he is so much more awake and attentive during the day now. All down to the looked after children's nurse knowing what to do."

They went on to tell us;

"If we have a child placed into the home from another area we just do not get the same service or response that we get from our own local looked after children's nurses. They are always available for advice, we get copies of all health assessments when it is appropriate and the information in them relates to our own care plans as well."

We spoke with the father of a child visiting the paediatric A&E. They told us;

"I wasn't happy with how the doctor spoke to me. I was worried about my (child) and didn't know where to go. He asked me why we had come here and said I should have gone to my GP. But I couldn't see my GP as it was the middle of the night when my child got sick."

We spoke with another parent at the paediatric A&E. They told us;

"The nurse that triaged my (child) was really kind and caring. She took the time to explain everything that she was doing and why they were doing it."

Another parent said;

"I am here a lot with my (child) a lot as they have type one diabetes. The doctors and nurses are nice, very re-assuring, and tell me what's happening all the time."

We spoke with young people accessing care and support from the young people's substance misuse services, RU-OK. They told us;

"They helped me come off drugs and stop using alcohol. Definitely high praise for my workers. They are special people to me."

They went on to say;

"They were spot on with confidentiality and always talked to me first. I know just what I am signing up to."

Another said;

"I wouldn't be here without them and moving to the adult service was done really well. I met with both sets of workers before the move."

We spoke with another young person who used the same service. They told us;

"The staff are friendly, kind and are there to help you no matter what. Confidentiality is important, but they tell me if they need to and are going to share information with other people. For example, they will tell other people if you aren't safe which is OK with me."

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 There were two health practitioners at the Multi-Agency Safeguarding Hub (MASH (also referred to as the 'Front Door for Families')) into which referrals were initially made, who provided full time cover between them, supported by a part-time administrator. We saw that the administrator played an important role in supporting those practitioners by undertaking system checks and contacting, for example, GPs requesting further information when required.

Although the health presence was good, there was some risk that, should a practitioner need to take sick leave for example, then there might not be adequate health presence at the MASH. We also heard that those health practitioners did not always have capacity to attend all strategy discussions due to their current workload. However, we were aware that this risk had been mitigated by named safeguarding professionals within local health Trusts being made aware of, for example, GP contact details, so should MASH managers have requested information input during a health professionals' absence, then the role would have been covered and so inform the decision-making process appropriately.

1.2 Both health practitioners based in the MASH had varied and relevant professional backgrounds within health disciplines to aid strong multi-agency working. During the course of a working week, they both returned to their particular nursing roles as well as undertaking their duties within the MASH. This was important so as to maintain a good understanding of roles and responsibilities and so not 'lose touch' with changes and developments across the health landscape and understand the need to provide support to vulnerable children and young people at the earliest opportunity.

1.3 Health practitioners within the MASH not only played an important role in safeguarding vulnerable children and young people in Brighton and Hove, but also to those visiting or placed within the area. When a referral was made into the MASH, the on-duty manager would review the assessment and request, where appropriate, further health assessment and exploration of records. Although those health practitioners did not review every referral made into the MASH, we were assured by live case examples and case records examined, that they were routinely asked to inform the safeguarding process appropriately considering the type of referrals received.

We examined one case example where a social worker in the MASH approached the health practitioner to request their advice and input on a 'live' case. It transpired that the subject of the case had suffered injuries that had multiple explanations by their parents at the A&E. We saw how the health practitioner immediately undertook examination of health records and found that the child had attended the A&E but was later discharged, and that they were also registered with a local GP.

It was recommended that, due to disclosures made since the A&E attendance, the child should be the subject of further medical examination. A strategy meeting was convened so that the case could be discussed by multi-agency partners and a decision made as to how to progress the case and keep the child safe.

1.4 Brighton and Hove is an established holiday resort and had a high number of visitors into the area, especially, for example, during school holidays. MASH health practitioners were aware of this and so would routinely make enquiries from GP practices and other services regarding vulnerable children visiting from out of the local area. This was important to ensure that, should a strategy discussion be held, the decision-making process was not hindered by a lack of relevant information being made available to inform the safeguarding process.

In another case examined we saw how a child was taken by police into protective custody due to the alleged abusive behaviour of a parent. The family had been visiting and staying in the area on holiday. The health practitioner and the administrative assistant began interrogating electronic systems, and soon identified that the child was registered with a GP in their home area away from Brighton and Hove. In the meantime, a telephone strategy meeting was arranged with social services from the child's home area so that information could be shared, and a decision made regarding progressing the case. Checks were also undertaken to see if the child had attended an A&E department in Brighton.

A call was made to the child's GP and information shared and this information then went on to inform the subsequent strategy discussion so that the child could be kept safe.

1.5 Referrals into the MASH via the Front Door for Families (FDFF) could be made initially by telephone. Where advice given was to make a formal written referral, we saw that those referrals could be made either by email, using a generic form, or any other method should the person making the referral not have access to that form.

Referral officers at the FDFF then assessed the referral and began undertaking their own checks including checks of the Child Protection Information Sharing system (CPIS), an electronic records system that identifies when a child is known to social services and is a looked after child or on a child protection plan. Basic information about that plan could be shared securely between social services and the NHS, meaning that health and social care staff had a more complete picture of a child's interactions with health and social care services.

Referrals were then rated Red, Amber or Green (RAG rated) by managers and, where appropriate, those health professionals then undertook their own checks using patient electronic records or by telephone calls made to, for example, GPs. This system ensured that the most relevant and important information was gathered in a timely way so that important safeguarding decisions could then be made to better protect vulnerable children and young people.

1.6 Maternity services in Brighton and Hove were provided by Brighton and Sussex University Hospitals NHS Trust (BSUHT) with consultant-led services at the Royal Sussex County Hospital in Brighton and community services provided across the area. Pregnant women with complex mental health and substance misuse needs were supported by a range of professionals that worked from the 'One Stop Clinic'. This was providing women with access to perinatal health services, adult substance misuse services, specialist midwives, neonatologists and obstetricians. This 'open-access service' meant that pregnant women with complex needs could access maternity services, which in turn could keep vulnerable unborn children safe.

1.7 Clinics held in a broad range of locations across Brighton and Hove meant that expectant parents had good access to midwives and antenatal support. Clinics were being held at the Royal Sussex County Hospital (and the Princess Royal Hospital in Haywards Heath, although this was not a part of our review), children's centres and also at GP practices. This increased the visibility of universal maternity services. Midwives had well established links with other agencies such as the police. This was also ensuring that harder to reach, vulnerable women were being offered accessible antenatal care which was holistically meeting their needs.

1.8 Assessments completed by midwives regarding risk to women and unborn babies from their partners, was not always seen to be robust. Case records examined highlighted that there was good recording of partners' names and dates of birth. However, the booking document template had not always prompted more detailed enquiry about other risk factors that could impact on safeguarding, such as substance and/or alcohol misuse.

In one case examined, there was no evidence of the midwife being professionally curious. There was no evidence of details of a partner's other children and his ongoing contact with them having been explored. Had this been known, this could have informed more robust analysis of risk associated with the partner. Furthermore, maternity records completed by midwives and medical staff did not always record whether the woman was seen alone or if she was accompanied and did not capture the details of the person who she was accompanied by. ***(Recommendation: 2.1)***

1.9 Whilst midwives were referring consistently to the Hospital Independent Domestic Abuse Advisors (HIDVA) when they had identified that domestic abuse might be indicated, the recording of responses to questions being asked of pregnant women regarding the risk of domestic abuse required strengthening. We acknowledge that it is important to anonymise records that could easily be seen by others, such as hand-held notes that follow the expectant mother around, but more needed to be done to ensure that, where enquiries are made of domestic abuse, then those enquiries are, for example, appropriately recorded in the client's main records. This was particularly important should the mother have visited maternity services outside of the Brighton and Hove area.

An audit of records completed by the safeguarding midwife in 2019 found that five women had not been asked about the risk of domestic abuse, and if they had, their answers to such questions had not been recorded. This meant that professionals involved in their care would not be aware of all of the women's risks and vulnerabilities and limits their ability to effectively safeguard women and babies. ***(Recommendation: 2.2)***

1.10 The health visiting service in Brighton and Hove were well engaged in the provision of early help to young children and families. The use of strengthening families plans helped to co-ordinate support to those families with additional vulnerabilities. We examined evidence of, for example, a health visitor referring a case back to children's social care when the family refused to engage fully with the service and concern remained.

1.11 Children aged five years and under were benefitting from effective delivery of the five mandated health checks which were being delivered as part of the Healthy Child Programme. When checks were completed according to targets, this helped to monitor children's development and identify need and risk at an early stage and prompt onward referrals for additional intervention and support as required.

1.12 The school nursing service was accessible to children and young people through the provision of 'drop-in' opportunities for children, not only in schools but also in the community. School nurses had a regular presence at eight different community groups to include; Lesbian Gay Bi-sexual Transgender (LGBT), Young Carers and Brighton and Hove Global Social Clubs drop-in centres. There were good links with the local authority which was enabling school nurses to have good oversight of children that were electively home educated by their parents, or home schooled. This increased the reach of public health services to the diverse communities within Brighton and Hove.

1.13 School nursing services provided a good universal offer which was facilitating the identification of for health needs and vulnerabilities in children in reception, year six and year seven. In cases examined, children had benefitted from proactive practice which was identifying health needs, risks and vulnerabilities that otherwise may not have been detected. This was also prompting more detailed assessment. However, this could be strengthened further to include other key stages in a child's life as outlined by Public Health England (aged 12 to 13 years, school leavers and transition to adult services). This would ensure that children benefitted from the early identification of new or emerging health needs and risks.

1.14 In school nursing, tools were not used effectively to help identify and track children's changing needs. Significant events in children's lives were not always recorded on dedicated chronologies, such as when a child entered care or had attended the A&E. Where used, genograms lacked specificity regarding the family composition which weakened their effectiveness in mapping out complex family structures. Assessments of children who presented with emotional and mental wellbeing concerns relied on the skill and judgement of the professional and were not underpinned by the additional use of assessment tools. This could hinder the early identification of risk and need. ***(Recommendation: 3.1)***. *Public Health commissioners will also be notified of this finding*.

1.15 The Royal Alexandra Children's Hospital (RACH) was located within the grounds of the Royal Sussex County Hospital. It was provided by BSUHT and provided 24-hour emergency care for children and young people up to the age of 17 years. The A&E reception was well located and enabled staff and clinicians to continually monitor and observe children whilst they waited for assessment and treatment. This meant that interactions between children and the adults accompanying them could be observed and good clinical oversight maintained of children whose health might have deteriorated and required more urgent treatment.

There were also separate waiting areas away from the main paediatric A&E reception which were utilised by children and young with additional requirements, such as sensory needs, or those who had become distressed in a busy clinical waiting area. This is good practice in meeting the needs of vulnerable children and young people identified as having additional needs.

1.16 Children and young people who presented at the paediatric A&E in mental health distress were benefitting from timely support from the Paediatric Mental Health Liaison (PMHLT) Child and Adolescent Mental Health (CAMH) team. CAMH support was available 24 hours per day at the A&E department.

Clinicians we spoke with told us that, whilst seeking support from community CAMHS could have proved to be a challenge due to thresholds and capacity, the support that the PMHLT offered to the A&E was 'invaluable' and ensured that children with mental health needs benefited from timely, detailed assessment whilst in the unit and thus could have their needs met at the earliest opportunity.

1.17 The children's A&E at RACH had a safeguarding assessment system which contained safeguarding prompts to screen for risk and vulnerability. Every child who attended the A&E was subject to a safeguarding assessment. However, a recent audit of patient notes demonstrated that the safeguarding assessment tool was only being fully completed in approximately 50% of all cases seen. This meant that we could not be assured that all children who presented at the paediatric A&E underwent robust safeguarding screening and thus received help at the earliest opportunity. ***(Recommendation: 2.3)***

1.18 The Royal Sussex County Hospital (RSCH) provided services to people aged over 17 years of age and also served as the regional trauma centre.

Despite a considerable number of young adults attending the RSCH A&E, no sperate paediatric triage documentation was available which contained age-related prompts to help clinicians to identify risk and vulnerability for young people aged between 17 to 18 years. For example, at the time of our visit there was no Child Sexual Exploitation (CSE) screening tool being used to support clinicians identify CSE should it be indicated. Therefore, there was too much reliance on professional curiosity to identify additional vulnerabilities and risk at an early stage. ***(Recommendation: 2.4)***

1.19 The 'Think Family' model was not sufficiently embedded within the adult A&E. None of the records we reviewed demonstrated sufficient exploration of associated children or dependants in the care of adult attenders, even when those adults were recognised to have exhibited risky behaviours. This meant that potentially vulnerable children and young people might not be identified and then have protective measures considered, such as those that might be implemented following a referral to children's social care. ***(Recommendation: 2.5)***

In one case examined, we saw that a female had attended the adult A&E with sudden onset abdominal pain. There was no evidence in the patient record of her partner details being explored and recorded or any further exploration of the potential cause of the pain, such as domestic abuse and/or violence. If any such questions had been asked by the practitioner assessing her, then those questions and any associated answers had not been recorded.

There had also been no exploration of whether the patient had dependent or carer responsibilities to any children and, if she had, then were those children in a safe place whilst she received care and support in the A&E

1.20 Within the adult A&E records reviewed demonstrated that, where safeguarding questions and prompts were provided, they had not always been completed. We were told that this is because clinicians often document and detail safeguarding concerns elsewhere within patient records. However, in the paper records seen, we noted that there was insufficient exploration of safeguarding concerns and documentation was further often illegible. ***(Recommendation: 2.5 as at 1.19 above)***

1.21 The Practice Plus Brighton Station Walk in Centre (WiC) provided a comprehensive NHS GP service and more convenient appointments and access to a GP or nurse practitioner.

Information sharing between the WiC and other disciplines and agencies was seen to be variable. We saw that GPs outside of the WiC were routinely notified of all attendances via discharge letters within 48-hours, including those GPs outside of Brighton and Hove. Where safeguarding concerns were known or identified, a verbal handover was completed where possible.

However, health visitors and school nurses from 0-19 services, were not notified of any attendances by children and young people at the unit. This limited the opportunity for practitioners in universal services to hold a complete health record that may have impacted upon actions and interventions required and provided by them. ***(Recommendation: 1.1)***. *Public Health commissioners will also be notified of this finding*.

1.22 Children and young people up to 18 years of age in Brighton and Hove living with emotional well-being and mental health needs benefited from timely access to appropriate service provision.

Sussex Partnership NHS Foundation Trust (SPFT) formed part of The Brighton and Hove 'Well-Being Service' in partnership with other providers to offer a variety of support services. SPFT also provided specialist CAMHS within the Children and Young People's Service (ChYPS). This meant that, following triage by a qualified practitioner, children and young people were offered the most appropriate service to meet their identified needs at the earliest opportunity.

1.23 Children and young people receiving support and intervention from specialist CAMHS generally benefited from a multi-disciplinary and multi-agency workforce who communicated effectively. Most records we reviewed clearly demonstrated appropriate information sharing between CAMHS and services such as adult mental health and children's social care. This meant that the majority of practitioners working with children, young people and their families were in possession of a complete picture of the needs, risks and circumstances that may have had a negative impact on young people's lives.

1.24 Although multi-disciplinary and multi-agency information sharing between and from the CAMH service was generally effective, more work is required to ensure that GP's who are the primary record holders of children and young people who receiving CAMHs support, are kept up to date with treatment and interventions being provided by CAMHs. In one record reviewed, gaps in information sharing was evident as a young person had experienced an episode of mental health crisis, but the GP had not been informed of this and as such their records were incomplete. ***(Recommendation: 4.1)***

1.25 Children and young people in Brighton and Hove attending the paediatric A&E in mental health distress benefited from timely access to crisis support from the CAMH service. The mental health liaison team based within the children's hospital enabled a crisis response to the most unwell young people within four hours. This meant that children and young people were assessed quickly and had immediate safety planning put in place.

1.26 Mental health services for adults with mental health needs in Brighton and Hove were provided by SPFT who worked in close partnership with the local authority.

A number of social workers were seconded to work in effective partnership with clinical staff to ensure that the multiple and often complex needs of adults with mental health concerns were met. The integration between health and social care teams was effective in ensuring that some of the most vulnerable adults and children of adults living with mental ill health were generally safeguarded effectively.

1.27 Young people in Brighton and Hove had good access to dedicated young person's sexual health clinics across the city as provided by the Sexual Health and Contraception (SHAC) service. Three clinics provided a walk-in service across Brighton and Hove and two clinics provided services to young people aged 20 years and under where demand for service was geographically noted to be highest. SHAC offered a free and confidential specialist service open to everyone regardless of age and sexuality, providing an equitable sexual health service across the area.

We heard of comprehensive outreach services being offered to harder to reach and difficult to engage young people. Two sexual health practitioners were able to take referrals from practitioners and professionals and also offer more intensive support to young people who might not ordinarily engage with the service, thus meeting their needs at the earliest opportunity.

1.28 The SHAC service had recognised that further work was needed to ensure the service met the needs of young living with a learning disability. Although at an early stage, the liaison health advisor was, at the time of our review, consulting with the trusts learning disability nurse to examine what adjustments could be made to the service to meet the additional needs of this cohort of young people.

1.29 Young people in Brighton and Hove had access to a well-developed substance misuse service as provided by Ru-ok? a local service working alongside under 18s whose lives were affected by substance misuse. The service provided support to young people up to 18yrs of age and was delivered as part of the local authorities' adolescent health offer. The service was responsive to young people's changing needs, triaging young people and offering support services promptly and so meeting their needs in a timely way.

1.30 Young people attending both the paediatric A&E with drug or alcohol related issues were automatically referred for further assessment to Ru-ok? An established pathway ensured young people were referred to the service via the paediatric liaison nurse. The young person was then invited to meet with an Ru-ok? care co-ordinator.

If the young person was known to other services, information was be shared when appropriate consent had been obtained.

Although this was an opt-in process for the young person at the time of our review, approximately 20-30% of all young people referred to the service opted to engage in support to address their substance misuse. However, we heard that where a young person declined to engage in treatment, consideration was given to making a referral to social services should there be any safeguarding concerns identified. In one tracked case we examined we saw that such referral resulted in positive engagement with the service with the young person being supported to make healthy lifestyle choices.

1.31 The 'Pavilions' adult substance misuse service saw in the region of two and a half thousand clients each year within the Brighton and Hove area. Around half of those clients were in structured, ongoing treatment and the other half had open access to the service or were receiving recovery support.

We examined evidence of the 'think family' model being well established within the Pavilions service. We examined examples of comprehensive assessments being undertaken with new clients which were reviewed every three months, or earlier should a client's personal circumstances change or if risk dictated. Likewise, parenting capacity assessments were also undertaken, and we saw that these too were comprehensive and reviewed on a regular basis.

Children in the care of adult service users were clearly identified within client records, including; dates of birth, schools attended if relevant and contact details of any social workers involved with the family. Also recorded well were other significant adults, such as grandparents or absent parents. This meant that potentially hidden children in the care of adults who might abuse alcohol or other substances could be identified at the earliest opportunity so that appropriate referrals could be made, and support provided.

1.32 There was a good offer by the OASIS element of the Pavilions service to families by way of a creche where adult service users could leave their children so that they could attend appointments for example, or if they needed 'time to themselves'. Oasis helped women, children and families make choices that lead to positive change for themselves, their families and their communities. We heard how the creche's provided care co-ordinators an opportunity to observe interactions between adults and children and to report concerns, if considered necessary, to the MASH.

1.33 One GP practice visited specifically recognised the additional support needs to travelling communities. Particular note was made, for example, to patient literacy skills and so additional support was provided by staff to ensure those patients understood information provided to them. For example, we were advised that this had led to an improvement in the take up of immunisations in traveller community children which provided further opportunity to identify need at an early stage and ensure that those children were kept safe.

1.34 One GP practice we visited during our review reported they had been unsuccessful in establishing multi-disciplinary meetings with health visitors and school nurses who had been involved with families registered at the practice. This was a significant deficit in joint working and sharing of information to better support families. ***(Recommendation: 1.12)***. *Public Health commissioners will also be notified of this finding*.

2. Children in need

2.1 A recent piece of work had been completed to ensure that frequent attenders at the adult A&E, including young people between age 16 to 18 years of age, were identified and had their vulnerabilities met. Arrangements were in place to ensure that people who frequently attended the unit benefited from multi-disciplinary oversight and support. Monthly high-intensity user meetings, with included practitioners from adult mental health, took place to discuss the needs of frequent attenders and to formulate a care plan which addressed identified risks and needs. This meant that vulnerable patients had their multiple and often complex needs responded to in a consistent way, including meeting the needs of vulnerable young people.

2.2 Pregnant women with additional vulnerabilities benefitted from good access to a range of enhanced support from midwives. This included; a young person's midwife, perinatal mental health services, substance misuse services and more recently support was developed for transgender clients. This helped to better meet the needs of those in their care, identify additional vulnerabilities and meet the needs of vulnerable pregnant women and their unborn children within the diverse communities of Brighton and Hove.

2.3 The quality of assessments completed with expectant parents was varied within midwifery services, and this limited the identification of risk and the effectiveness of safeguarding practice. In one case examined, an assessment completed by an obstetrics and gynaecology doctor failed to assess safeguarding risks of a pregnant woman and their unborn baby prior to discharge. The discharge plan was poor, and assurance that an effective safety plan had been implemented was weak which resulted in a potentially unsafe discharge. Assessments completed by midwives when women booked their maternity care were not always thorough or consistent. ***(Recommendation: 2.6)***

2.4 Dedicated fields on assessment documentation within midwifery regarding mental health were not always completed and known concerns then shared to effectively inform a care and support package. This limited the early identification of known risks that could have informed more fully people's ongoing care and needs. ***(Recommendation: 2.6 as at 2.3 above)***

2.5 In maternity, assessment tools were under used and this placed too great a reliance on individual staff professional curiosity to identify safeguarding risk. Tools to aid the identification of neglect, such as the graded care profile or for use where, for example, CSE might be indicated were not used by midwives to underpin the assessment of those in their care. ***(Recommendation: 2.7)***

2.6 Expectant parents had not benefitted from good access to a continuity of care from their maternity carer. This was particularly key for those expectant parents with additional vulnerabilities and who were harder to engage with, although specialist midwives for substance misuse, homeless people, teenage pregnancy and travelling communities for example, will provide support and continuity of care when vulnerable women are identified. There was a risk that inconsistency of care provision and sometimes inadequate record keeping, and assessment of risk, meant that safeguarding concerns might not always be identified and reported and specialist support provided by those specialist midwives.

Leaders had been awarded funding to increase maternity staffing, but at the time of our review additional staff were not yet in post. ***(Recommendation: 2.8)***

2.7 There were good links between the health visiting team and the perinatal mental health service. The dedicated specialist perinatal mental health visitor attended triage meetings with other health visitors that facilitated joint working. The specialist health visitor was not a caseload holder, but they had provided consultation and specialist advice to other health visitors to help meet the needs of those women with identified or emerging mental concerns.

2.8 Joint working and liaison between health visitors and GPs to meet the needs of children and their families was limited and variable. While there were linked health visitors to each GP practice, the way they worked together differed. In cases examined, we saw little evidence that information was shared between the health visitors and GPs to ensure both disciplines had a shared understanding of risks and needs and how this was met. In one case, mental health support that both disciplines had provided to a parent was not undertaken in partnership which resulted in a lack of awareness of the overall impact this had for the parent and child. ***(Recommendation: 3.2)***. *Public Health commissioners will also be notified of this finding.*

2.9 In health visiting, routine enquiry of domestic abuse was not embedded in best practice which hindered the identification of new or changed risk. Leaders expected staff to complete routine enquiry into domestic abuse at every contact if it was safe to do so. However, cases examined identified that this expectation was not always followed. In one case seen, the health visitor had not completed any check about domestic abuse even though it was safe to enquire during meetings with the expectant mother. In another case, the health visitor identified domestic abuse and, while they completed a timely referral to children's social care, there was no evidence of any agreed safety plan with the parent to ensure the safety of the child. It was not always clearly recorded if the health visitor had spoken with women alone. ***(Recommendation: 3.3)***. *Public Health commissioners will also be notified of this finding*.

2.10 Tools that underpinned more detailed assessment of risk and vulnerability were not utilised routinely by health visitors. This placed too great a reliance of professional curiosity. Where enquiries were made about domestic abuse, tools were not used to identify the level of risk and further to track and monitor any changed risk. In one case examined, domestic abuse was identified twice but as no tool was used as part of the assessment process this tracking to monitor if risk was escalating or de-escalating was limited.

At the time of the review tools to aid the identification of neglect had not been implemented. However, we were aware of an intent to introduce the graded care profile within the health visiting service, but frontline staff had not yet been trained in its use. ***(Recommendation: 3.4****)*. *Public Health commissioners will also be notified of this finding*.

2.11 The health visiting service had not made good use of chronologies to aid tracking of changed risk in children and families they cared for. In cases examined practitioners did not effectively record significant events in a child's life on the dedicated template in their electronic health record. Events not always recorded included; when children were referred to children's social care, entered into care, became the subject of a child protection plan, were discussed at Multi-Agency Risk Assessment Conferences (MARAC), had attended the A&E or had changed their home address. This prevented staff from having efficient access to known incidents that would aid the detection of escalating or even de-escalating risk that might have required them to act to safeguard vulnerable children. ***(Recommendation: 3.5)***. *Public Health commissioners will also be notified of this finding*.

2.12 School nurses worked flexibly with hard to reach children and families to engage them with services that they provided. Where appropriate, this included conducting home visits which helped the school nurse to assess risks posed by the child's home environment. In one case examined we could see that this helped to underpin existing professional concern for a child and enhanced their awareness of sensitive cultural issues. This resulted in the child being escalated from early help to child in need and then to a child protection plan before they eventually became looked after.

2.13 In school nursing, children with additional vulnerability were, on the whole, highly visible in their electronic health records. We could see that alerts and flags used highlighted to staff that children were, for example, looked after, had been the subject of child protection measures or required an interpreter during one-to-one interactions.

2.14 Children and young people aged 11 to 19 years had additional access to the school nursing service through a text service called 'Chat Health'. The service was operational Monday to Friday, 09.00 to 16.30 Monday. This was a confidential service that could facilitate the signposting of children to the services they needed, for example, to sexual health advice and support.

School nurses promoted Chat Health in a number of ways including; at school assemblies and at immunisation sessions. Activity regarding the service was reported quarterly to leaders which helped track the reach and impact of the service.

2.15 In school nursing, there was more to do to ensure that children missing from education benefitted from access to the healthy child programme. We recognised that steps had been taken to address this gap through strengthened links with the local authority to help, but at the time of the review this was yet to be resolved. As a consequence, those children were not visible to the school nursing service. ***(Recommendation: 3.6)***. *Public Health commissioners will also be notified of this finding*.

2.16 Relationships between the school nursing service and GPs were underdeveloped which hindered joint working to safeguard vulnerable children. In cases examined, we saw little evidence of effective information sharing about children's changed needs between both health disciplines. This limited a shared understanding of risks and protective factors and how children were safeguarded. Furthermore, school nurses were not well sighted on children that were newly registered at GP practices after moving into the Brighton and Hove area. If known, this information would help to ensure that those children benefitted from timely access to the healthy child programme. ***(Recommendation: 3.2 as at 2.8 above)***. *Public Health commissioners will also be notified of this finding*.

2.17 Families where English was not their first language were well supported by the health visiting service. This facilitated access to appropriate services, such as interpreters, to aid communication with parents/carers. This ensured that families better understood advice provided by the health visitor and in turn the health visitor understood their family's needs well.

2.18 The Acute Children's Outreach Nursing Service (ACORNS), monitored children who had received treatment in the paediatric A&E at home when there were additional concerns that the child's medical presentation may have deteriorated post discharge, or when there were safeguarding concerns and additional vulnerabilities identified.

The home visits provided by the ACORNs team (which comprised of registered paediatric nurses) also provided opportunities to see children in their home environment and identify additional safeguarding concerns and risks and so safeguard them better.

2.19 The paediatric liaison nurse for the BSUHT reviewed attendances of young people aged between 17 and 18 years who attended the adult A&E where there had been identified safeguarding concerns. However, the absence of appropriate paediatric prompts and screening tools limited clinicians' ability to identify concerns associated with every young person who attended the unit. This meant that some vulnerable young people may not have had their needs identified and met and may not have been effectively safeguarded although the safeguarding liaison nurse attends all four Brighton and Hove A&E departments and reviews all child and young person attendances.

2.20 We saw effective and well embedded partnerships between the adult substance misuse service and the adult A&E. A practitioner from the Pavilion substance misuse service attended the adult A&E daily to screen attendances and to identify patients who might have abused alcohol or other substances. This cohort of patients were then encouraged to engage with care co-ordinators from Pavilions to support to address their substance misusing behaviour and also identify potentially vulnerable children and young people in their care.

2.21 When the adult A&E at RSCH received a paediatric trauma call, an alert was sent to the Royal Alexandra Children's hospital which was situated next door. A specialist on call Paediatric trauma team were then dispatched to RSCH to assist where necessary. This ensured that children with the most acute needs were treated by appropriately skilled and trained clinicians at the earliest opportunity.

2.22 Children and young people who attended the WiC did not routinely have their risks and needs above the presenting complaint identified or assessed. There were, for example, no additional templates available for practitioners to use in the assessment of children or to support the identification of risks, such as child exploitation. The routine enquiry on domestic abuse and violence was also not embedded.

This meant that children and young people could leave the WiC without being offered, or referred to, additional support and intervention required to help keep them safe from abuse or harm. ***(Recommendation: 1.2)***

2.23 The 'Think Family' model was not embedded into practice within the WiC. Adults who attended the WiC were rarely asked if they had regular contact with, or caring responsibility for children and young people. There was an over-reliance on the professional curiosity of the individual clinician to ask those important questions.

This increased the likelihood of 'hidden children' being left at risk when adults' health, behaviours or circumstances could have had a negative impact on the well-being of children in their care. ***(Recommendation: 1.3)***

2.24 Children whose parents or carers decided not to wait for consultation at the WiC were not routinely 'followed-up' to ask about the reason for their not waiting or to check on the safety of the child bought to the centre. There was no 'did not wait' policy in place at the WiC which meant that children not seen having been taken away prior to a consultation taking place might have had unmet needs. ***(Recommendation: 1.4)***

2.25 We found the Sexual Health and Contraception (SHAC) practitioners were recording information within the free text section of client records generally very well, especially in relation to the young person's social history. However, records could be strengthened further if it was clearly articulated from who the recorded information related to, such as the young person or an accompanying adult. ***(Recommendation: 2.9)***. *Public Health commissioners will also be notified of this finding*.

In one case examined within the SHAC service, we saw how a young person had attended the service with a parent acting as guardian. Although the recording of information within the record was good it was not clear who had been answering the questions asked, the young person or the parent? It was not clearly evident if the 'voice of the young person' had been requested or recorded and as such we could not determine if the record accurately articulated that young person's circumstances and feelings. It was also not recorded if the young person was seen alone at any point during the assessment process.

2.26 Within the SHAC service, saw a number of examples where liaison and information sharing between the service and multi-disciplinary and multi-agency partners had supported the safeguarding of a young person in their care. For example, following referral from a social worker to the service, the social workers name and contact details were recorded on the young person's care record and further, subsequent discussions held with the young person regarding why an issue needed to be shared were also recorded well. This meant that any other practitioner having to access that record could be well aware of any risks to the young person and so adjust their interactions accordingly.

2.27 We heard of a comprehensive outreach service being offered to young people by the SHAC service. Two sexual health practitioners were able to take referrals from multi-disciplinary practitioners and professionals and so offer more intensive support to young people. We heard of an example of a young person attending a drop-in clinic who was then referred to a SHAC clinic where further exploration of their emotional wellbeing was undertaken. This had led to the young person being referred to other supportive services alongside contraceptive advice being provided.

This approach recognised that young people may need to develop a healthy rapport with practitioners before progressing on to consider different options of care and support.

2.28 Young people who required support for habitual and problematic substance misuse benefited from specialist support provided by Ru-ok. The tier three specialist service worked in a holistic and child centred way to engage young people in treatment. This may have been achieved, for example, by visiting young people in a setting of their choice and carrying out joint assessments with other health professionals to reduce the multiplicity of health assessments. We also saw an approach of using the individual expertise of team members to develop the right care plan for young people. This approach recognised the complexity of young people's lives and the joint expertise needed to support them.

2.29 Young people across Brighton and Hove were offered the services of the Drugs, Alcohol and Sexual Health education workers (DASH) in the community setting. The tier two substance misuse offer had a number of initiatives to engage with young people and their parents through an education and prevention service. Co-run 'drop-in' sessions in association with school nurse practitioners were offered within a number of local schools. School-based appointments were also available to young people and targeted brief-intervention programmes were used when substance misuse had been identified.

This formed an early help model for substance misuse intervention with a strong focus on engaging parents and families in the process.

We also heard of an initiative where young people who had been excluded from school due to a drug related issue were referred to Ru-ok and an appointment was usually offered within 24hrs to discuss with them and their parents the context of the situation and offer support as needed. This was giving young people quick access to practitioners who could help them to consider the impact of their actions decide what support would be effective for them.

2.30 Consideration of the emotional health and wellbeing of young people seen at Ru-ok was well developed within the service. For example, CAMHS workers were employed within the team and offered direct work with the young people who presented with co-existing mental health and substance misuse needs, or to provide support and expertise to team members. They also had close links with the mainstream CAMH service. We examined a case where joint discussions had been undertaken to ensure both services were familiar with the care plans each were offering the young person. This approach supported appropriate information sharing and child focused care.

2.31 Leaders within Pavilions adult substance misuse service attend MARAC meetings and routinely shared information at those meetings. We saw evidence of information received at MARAC meetings being recorded well in client electronic records. This meant that children and young people in the care of adult clients were better protected from the risk of witnessing or being involved in domestic abuse and violence incidents.

2.32 In both GP practices visited, we were advised that, although notified of patients who are to be discussed at MARAC and then the practices sharing information to inform those meetings, the practices were not routinely informed of outcomes from the meeting once discussions had concluded. This meant that those GPS, as primary record holders, might not be in receipt of important safeguarding information regarding domestic abuse and violence so as to inform their interactions with those families. ***(Recommendation: 1.5)***

3. Child protection

3.1 In maternity, risk assessments of the home environment were limited because community midwives did not routinely visit expectant parents at home. In one case examined, the community midwives had not been notified of a birth which delayed the completion of planned maternal and infant checks and further consideration of hazards within the home. ***(Recommendation: 2.10)***

3.2 CPIS was established on the labour ward within midwifery services. This increased the visibility of known safeguarding information should 'un-booked' women attend the unit in labour, particularly those from outside of the Brighton and Hove area.

3.3 In maternity, the quality of referrals that were made to children's social care varied. While staff had taken the right action to refer their safeguarding concern for unborn babies, even at a very early stage of pregnancy, the contextual information included in referrals seen could be strengthened further. For example, the details of linked adults and children had not always been recorded and further analysis of risk and protective factors lacked sufficiency and detail. Furthermore, the referrer had not always made clear what action they wanted children's social care to take following the referral being made. This risked delaying unborn babies' access to the help and protection they needed should the strength of the referral mean that it was not accepted for further action. ***(Recommendation: 2.11)***

3.4 Assurance that the exchange of information at MARAC could be strengthened within maternity services. BSUHT were reported to attend MARAC meetings where high-risk domestic abuse cases were discussed. The safeguarding midwife we spoke with reported maternity shared relevant information to MARAC and received outcomes from those meetings.

We are aware that any pregnant woman discussed at MARAC will have a social worker and a safeguarding birth plan in addition to any MARAC safety plan. However, in one case examined, while we could see a MARAC flag was placed on the maternity electronic patient record, there was no evidence that information was shared at the MARAC or the outcome of the meeting received. As a consequence, it was unclear what multi-agency plan was agreed to safeguard the unborn from high risk domestic abuse. ***(Recommendation: 2.12)***

3.5 Overall, midwives were well engaged in multi-agency working to safeguard those in their care. Midwives attended child protection case conferences and, when the information was secured in records, they completed reports that were accompanied by a chronology of significant events. This ensured that partners focussed on the maternity care women and unborn babies/infants required during the decision-making process at those meetings.

3.6 Health visitors recognised when children and families needed help and protection and completed timely referrals to children's social care when risk was identified. This was done using different formats, such as via email or using the dedicated local authority electronic template. In cases examined we saw that the quality of referrals was sufficient and detailed.

3.7 Health visitors were seen to be good advocates for children and would, where necessary and supported by an appropriate escalation policy, challenge decisions made by children's social care to secure the help they thought children and families needed.

In one case tracked, both within the health visiting service and at the MASH we saw how a health visitor had made a timely and detailed referral to the mash, clearly articulating risk and desired outcomes. However, the referral was rejected by the MASH and this was fed back to the health visitor.

We then saw and heard how the health visitor then sought advice from their safeguarding lead and, following a discussion which was appropriately recorded in the patient's record, a challenge was sent to the MASH outlining the reason for the challenge and further highlighting detail already included on the original referral and how the health visitor believed that the matter should be the subject of further discussion.

The outcome of the challenge, which we saw was clear and appropriate, was that managers within the MASH reviewed again the evidence and decided that their original decision was wrong and further that a strategy discussion meeting be convened to discuss the case further.

3.8 In health visiting, we were not assured that the procedures for MARAC were effective. In one case that had been discussed, we saw the relevant alert regarding the risk of domestic abuse was not added to the child's electronic health record so as to readily inform staff accessing that record of any associated risk. For the same case, we also identified that the exchange of information held by Sussex Community NHS Foundation Trust (SCFT) with partners was poor. The minutes from the MARAC had indicated a member of SCFT staff was present at the meeting, but they had not shared relevant information from the record. This limited the effectiveness of multi-agency safeguarding decision making in a recognised high-risk case of domestic abuse. ***(Recommendation: 3.7)***. *Public Health commissioners will also be notified of this finding*.

3.9 In school nursing, the quality and timeliness of referrals made to children's social care required strengthening. Referrals examined were detailed in explaining the circumstances of the referral but had not articulated clearly enough children's lived experiences and the impact and level of harm professionals were concerned about. This risked delaying children's access to the help and protection they needed. While mangers reported they had oversight of referrals through informal liaison and case discussion, this was not always detected within records examined. ***(Recommendation: 3.8)***. *Public Health commissioners will also be notified of this finding*.

3.10 School nurses were well engaged in multi-agency working across the continuum of need where they had an identified role. For example, we saw that there was good attendance to multi-agency meetings which included Adolescent Vulnerability Risk Meeting (AVRM). This ensured that the health and development needs of children could be considered which informed multi-agency decision making and planning so children's needs were better met.

3.11 CP-IS was in place in the paediatric A&E. This enabled clinicians to have greater oversight of transient and vulnerable young people on holiday in the area who may attend numerous unscheduled care settings in and outside of Sussex. However, we were told that not all staff had been issued with 'smart cards' and therefore were not always able to access information held on the CP-IS system in an efficient and timely way. Access to CP-IS was particularly limited out of hours when receptionists were not working. Although we are now informed that key staff have access to 'smart cards' allowing them access to CP-IS at the time of our review out-of-hours access remained, according to practitioners we spoke with, a problem.

This meant that at certain times, clinicians may not have been aware of all of the risks and vulnerabilities pertaining to the children and young people in their care. ***(Recommendation: 2.13)***

3.12 The lack of effective flags and alerts on the electronic patient record system within the adult A&E did not support clinicians to identify patients with additional needs and vulnerabilities quickly and easily. We saw how clinicians had to explore patient records to find any recorded safeguarding information. This restricted those clinician's working in a busy A&E environment from accessing safeguarding information swiftly which would be required to ensure that appropriate actions were undertaken to keep vulnerable adults and young people safe. ***(Recommendation: 2.14)***

3.13 Whilst there were arrangements in place to notify GP's when an adult or young person aged 17 and above attended the adult A&E, letters were not electronically generated upon discharge. This process was resulting in some delays in discharge summaries being received by GP's which meant that those GP's, as primary record holders, might not immediately be aware of safeguarding concerns at the earliest opportunity should a patient attend their surgery soon after discharge from the hospital. ***(Recommendation: 5.1)***

3.14 There was a good understanding of Fabricated and Induced Illness (FII) within the paediatric A&E. BSUHT had an up to date policy in place regarding this potential safeguarding issue so that staff would be better aware of how to identify and report FII should it be required and so better protect vulnerable children and young people.

3.15 Infants and children who were immobile and attended the WiC in Brighton with bruising were not offered a standardised response. Clinicians we spoke with were not aware of a 'bruising in non-mobile infants and children policy', and the action taken was based on 'expected practice' and the application of staff professional curiosity.

This did not support the early identification of harm through physical abuse or previously unidentified medical conditions. ***(Recommendation: 1.6)***

3.16 The contribution of CAMHS practitioners into child protection processes was variable. We were told that CAMHS practitioners submit referrals to the MASH, which were also routinely copied to the SPFT safeguarding team. Only one record examined however, referenced a referral made to the MASH but even that referral could not be reviewed as it was not stored on the record examined meaning that record was incomplete. ***(Recommendation: 4.2)***

3.17 In adult mental health, records reviewed demonstrated that safeguarding concerns were clearly 'flagged' as alerts on the electronic patient record system. This meant that practitioners could clearly identify patients who had additional vulnerabilities and risks, including those clients who had parental or carer responsibility to children who were subject to a child protection plan or were looked after.

3.18 Practitioners in the adult mental health team were not always considering the risks the unborn children of service users. In two records reviewed we saw that the service users were pregnant, were victims of domestic abuse and were also misusing substances. Whilst their risk-taking behaviours were clearly documented, practitioners had negated to document the impact that the risks identified might have had on the unborn children and so go on to appropriately safeguard those unborn children. ***(Recommendation: 3.9)***

3.19 Seconded social workers were aligned to adult mental health wards to support discharge planning and the robust assessment of risk. This arrangement ensured effective oversight and management of risk when a patient was discharged home, especially if there were children identified at that home.

3.20 Care co-ordinators within the Pavilions adult substance misuse service were well engaged in the child protection process. We examined detailed reports submitted to inform, for example, initial child protection meetings which clearly articulated risk to children in the care of adult service users. We also saw that those same care co-ordinators attended the meetings so that their evidence to inform the decision-making process could be given in person and added to should it be required.

Decisions taken at child protection meetings were generally fed back to Pavilions and then entered onto the client electronic records system. Where minutes from those meetings were not received then we saw that care co-ordinators would make effort to obtain them so that their clients records remained complete and up-to-date.

3.21 Completion of risk assessments within SHAC care record required strengthening. Although an assessment of vulnerabilities and risk of abuse and exploitation was expected to be undertaken at each attendance for all young people under 16 years of age, the completion of such assessment was inconsistent. This increased the risk of young people who might be vulnerable to, for example, child sexual exploitation not having their needs identified. The variability in the way that the template was completed did not give full assurance that all areas of concerns had been considered, explored and acted on to keep young people safe. ***(Recommendation: 2.15)***. *Public Health commissioners will also be notified of this finding*.

3.22 Where risks and concerns were identified the 'flagging' system for young people attending the SHAC service and identified as vulnerable was effective. A 'box' on the IT system alerted the practitioner at the earliest opportunity that there were safeguarding concerns to be considered regarding the young person. The system also enabled the young person to be highlighted for fast tracking when attending the service, such as looked after children and UCSA.

We examined an example of a young person with a history of going missing that had been discussed at the multi-agency AVRM group of which the SHAC service attend. This had led to an alert to be placed on the care record regarding the nature of the risk. This approach further enabled practitioners to share information with key individuals working with the young person and ensure a multi-agency response to safeguarding the young person was maintained.

3.23 In both GP practices we visited, we saw the appropriate use of flags and alerts on the electronic patient records systems to inform practitioners of vulnerabilities, such as when a child was in care, subject to a child protection plan or if domestic abuse was indicated. This ensured that GPs, as primary record holders, were kept up-to-date as to a child's circumstances.

3.24 Although we saw the appropriate use of 'flags and alerts' on electronic patient records within GP practices, in one practice visited we could not be assured that those alerts were reviewed in a timely way. For example, the practice was not confident the IT system supported them being aware of when children have been removed from a child protection plan or ceased to be looked after. To mitigate this in some way, the practice undertook an annual check, but this meant there might be some considerable delay in ensuring a patient record was accurate and up-to-date. ***(Recommendation: 1.7)***

4. Looked after children

4.1 In school nursing, cases examined showed that the timeliness and quality of review health assessments and plans for looked after children was a strength. Review health assessments seen were generally of good quality although the obtaining and explanation of consent between the practitioner and young person could have been articulated and recorded better in some cases seen.

4.2 Within the paediatric A&E, looked after children were clearly highlighted on the electronic patient record system as well as on CPIS. This meant that even staff that did not have ready access to CPIS would be able to identify when a child was looked after and so recognise their additional vulnerabilities.

4.3 We saw evidence of learning from a recent serious case review (more recently referred as a child safeguarding practice reviews) within the paediatric A&E. Clinicians had been provided with training by the named doctor for safeguarding regarding the additional vulnerabilities of looked after children, and used lessons learned to highlight that it should not be assumed that children and young people were automatically safe from abuse and harm when they were fostered or adopted. This highlighted to practitioners the additional vulnerabilities of looked after children.

4.4 Looked After Children in Brighton and Hove did not benefit from the timely completion of Initial Health Assessments (IHA). We were aware that there was ongoing monitoring of the data by the provider, CCG and local authority committees, but trajectories to support driving improvement were limited and not strong. This meant that looked after children in Brighton and Hove were at risk of not having their additional vulnerabilities identified and mitigated at the earliest opportunity. ***(Recommendation: 6.1)***

4.5 The process for undertaking IHAs did not align with statutory guidance for Looked After Children. IHAs for children over one year of age were undertaken by specialist children in care nurses from within the Children in Care Health Team (CiCHT) with paediatric overview being given through discussion at multi-disciplinary meetings. The expectation of the statutory guidance promoting the health and well-being of looked-after children (2015), is that nurses will have completed a paediatric assessment module to undertake this extended role. However, we were not assured that this was the case for all CiCHT practitioners at the time of our review who had undertaken IHAs.

We were further not assured the process of CiCHT practitioners undertaking IHAs included the collection of data to confirm all children had been discussed at the meeting to allow paediatric oversight. In one case examined, we saw that an IHA had been completed in May 2019 but had yet to be discussed at MDT at the time of our review. ***(Recommendation: 6.2)***

4.6 IHAs and Review Health Assessments (RHA) undertaken by the CiCHT specialist nurses for Brighton and Hove children living across Sussex were seen to be of a good standard. We saw good use of tools to support exploration of, for example, sexual health including CSE. Plans developed following the IHA or RHA were also seen to be of good quality and were appropriately shared with the child's social worker, GP and health visitor or school nurse. Where appropriate, they were inclusive of parent or carers views and articulated well the voice of the child.

4.7 Two RHAs undertaken by health visitors examined lacked detailed descriptions of the child's development and in one case, where it was not possible to weigh the infant, no further action was indicated in the plan to undertake this process, despite the assessment noting the child looked small. We were told by leaders that a greater focus on quality assurance of RHAs by the named nurse was planned but at the time of our review this had yet to take place. ***(Recommendation: 6.3)***

4.8 The CiCHT was using a number of the specifically designed documents and clinical tools available to improve health assessments for Unaccompanied Children Seeking Asylum (UCSA). The practice of the young people persons IHA being undertaken by a community consultant paediatrician supported by a specialist nurse with an Interpreter present was good practice. We also heard of work that had been undertaken with GP's and carers to reinforce that UCSA should be referred to services such as a dentist promptly to ensure unmet need could be addressed.

In one record examined we saw that an UCSA had an RHA undertaken at a local children's centre. It was noted that the young person should wear glasses while undertaking certain activities, but the young person had admitted that this was not always the case. We examined the review health care plan following on from the RHA and saw that there was a clearly written section which stated that the young person should be encouraged to wear their glasses by their foster carer and also that they be taken for regular optician appointments with this responsibility also clearly articulated.

4.9 Young people in care benefitted from specialised outreach contraceptive and sexual health screening services from the specialist nurse for looked after children. The CiCHT had additional funding from public health to provide the service to looked after young people to focus on reducing the risk of unplanned pregnancy and sexually transmitted infection. This allowed advice and care to be offered at the point of contact to the CiCHT without further onward referral always being necessary.

4.10 A process was in place to quality assure all health assessments undertaken for Brighton and Hove children and young people who were placed out of the area. We heard that all assessments were reviewed by the named nurses for safeguarding children and, at times, this had led to challenge with the area into which children were placed to ensure they received a good standard of care equitable with that provided to them in Brighton and Hove. RHAs for children and young people placed outside of the area were seen to be of good quality.

4.11 Young people were involved in devising the health passports that were offered to care leavers, and we saw that this was accompanied by a health record of the young person for their information. Although the service did not currently monitor the uptake of health passports or health records by care leavers which made it difficult to assess the effectiveness of current processes, young people we spoke with told us that they were aware of the process or if they had left care had received their health passport and were happy as a result.

4.12 There was good recognition of the additional needs of children living with autism who were also looked after. This included, for example, information about the health assessment process being sent to those children in a format which better met their needs, including the use of 'easy read' documentation and better description of the health assessment process. This was good practice, recognising the importance of involving this vulnerable group of young people in the health assessment process.

4.13 Looked after children were offered the Universal Plus Healthy Child Programme service by Brighton and Hove health visitors and school nurses. Universal Plus offered a rapid response from the health visiting team when specific expert help was needed, for example; with postnatal depression, a sleepless baby or answering any concerns about parenting. Practitioners undertook RHA's either in the home or place of choice of the young person. A new standardised assessment template had also recently been introduced enabling better quality assurance of the process.

4.14 We examined examples of effective multi-disciplinary working by the CiCHT, including well developed links with tuberculosis nurses in the acute hospitals. This allowed quick access and assessment of young people considered to be at risk of the disease, such as UCSA. We also heard of an approach taken by the school nursing team and CiCHT nurses to undertake joint IHAs for children with complex needs who were being educated in a local special school.

4.15 Children and young people in care benefited from access to early support for their emotional and mental health needs.

The provision of two clinical psychologists based within the looked after children's team enabled intervention whilst awaiting a specialist CAMHS assessment if needed. We were advised that there had been a reduction in the number of looked after children who required specialist CAMHS intervention as a result of the access to clinical psychologists at an early stage.

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 Multi-agency leaders understood well the importance of health input into the FDFF and the MASH overall. The two health representatives remained engaged with their core nursing practice and shared overall representation within the MASH. Although more administration support would have helped them prioritise their workload, we saw that the current arrangements do work and assists those health practitioners undertake investigations following referral to them. We also saw how other multi-agency practitioners within the MASH would approach the health representative to discuss individual cases in person where necessary, respecting their knowledge and input into the safeguarding process.

5.1.2 The existing arrangements for the provision of the statutory named midwife role was fragile. For example, there was no dedicated ring-fenced time given to the provision of the role which was identified as a concern in the BSUHT annual safeguarding children report of 2018-19. It was unclear how leaders had considered factors such as the birth rate and vulnerability of the local population to inform their workforce and resource plans for the statutory role. ***(Recommendation: 2.16)***

5.1.3 It was recognised by both the CCG and SCFT that current arrangements for undertaking IHAs for looked after children did not align with statutory guidance. A decision as to an agreed way forward had yet to be undertaken to ensure that all IHAs were undertaken by appropriately trained staff according to that statutory guidance, and qualitative data to support a model moving forward was not available at the time of our review. ***(Recommendation: 6.4)***

5.1.4 Record systems in the paediatric A&E were fragmented. We saw that some information was held on the electronic patient records system whilst other records were paper based. Whilst records reviewed were detailed and in the main contemporaneous, it was difficult to quickly and easily access information contained within records examined, which was important for staff working in a busy A&E department. ***(Recommendation: 2.17)***

5.1.5 Similarly, record systems within the adult A&E were also seen to be fragmented. Triage and discharge notes were held on the electronic patient records system while other notes were completed on paper records. Neither records are therefore complete. Staff within the unit we spoke with told us that they found the current record keeping arrangements challenging and accessing key safeguarding information, for example, could prove to be time consuming. ***(Recommendation: 2.17 as at 5.1.4 above)***

5.1.6 GP letters and copies of referrals made to children's social care were not always present in the records we examined within the adult A&E and they were not routinely uploaded to the electronic patient record. This meant that those records did not provide a full, holistic picture of a patients known risk and vulnerability. ***(Recommendation: 2.17 as at 5.1.4 and 5.1.5 above)***

5.1.7 We heard that a number of clients living with mental ill health also had co-existing substance misuse issues which would often exacerbate mental health conditions. We were informed by adult mental health practitioners we spoke with that, whilst they valued the input and advice provided by the adult substance misuse team, it was often challenging to obtain support and intervention for adults who did not want to address their substance misusing behaviour. This is despite some mental health conditions, such as anxiety, making it difficult for some adults to access further intervention and support.

We were informed by Pavilions that there should be no barrier to people accessing care and support where a dual diagnosis was identified. However, we were further unaware of any formal managerial protocol being in place to inform and guide multi-disciplinary practitioners who might have been working with clients accessing services from both adult mental health and adult substance misuse. ***(Recommendation: 4.4)***. *Public Health commissioners will also be notified of this finding*.

5.1.8 With support from leaders and managers, the liaison health advisor within the SHAC service had worked with the organisers of various 'Pride' events that were held in Brighton annually to raise the profile of the service to young people who attended those events. We heard the multi-service collaboration aimed to give a coordinated approach and message to support the diverse population of the area.

5.1.9 The SHAC service had developed services to meet the needs of the local areas identified diverse community. A transgender clinic for young people under 18 years of age had been established recognising the individual needs of this particular group of young people within Brighton and Hove. This demonstrated that services are being commissioned to meet the diverse needs of the local population.

5.2 Governance

5.2.1 In maternity, record keeping arrangements were too fragmented and hindered access to a complete record of women's care which was inefficient and could be considered a risk. We were aware that a service specification had been developed to procure a dedicated electronic patient record, but this was yet to be completed. We were told this was on the BSUHT risk register, but at the time of our review plans to resolve this issue lacked pace. ***(Recommendation: 2.18)***

5.2.2 In the health visiting service, standards of record keeping were seen to be varied. In one case examined we found a report for a child protection case conference that was for another child. In another, safeguarding supervision was reportedly completed but there was no evidence of this contained within the child's record. In another case, the health visitor identified domestic abuse but had not recorded this in the dedicated field of child's electronic health record. This practice fell short of professional standards and, although swift action was taken by staff to remove the report identified as being within the wrong record, more work was required to ensure the accuracy of records and that information governance directives are maintained. ***(Recommendation: 3.10)***. *Public Health commissioners will also be notified of this finding*.

5.2.3 There is more to do to ensure that the 'Think Family' model was embedded within the adult mental health service. For example, the SPFT safeguarding team were unable to tell us how many adults known to the adult mental health service had dependent children or links with children. It was acknowledged that more robust data recording was needed to provide greater oversight and assurance that the risks to children are being consistently identified and met. ***(Recommendation: 3.11)***

5.2.4 Within health visiting, the Named Nurse and Healthy Futures team leader used audit effectively to evaluate standards of practice. Earlier in 2019 they audited safeguarding and record keeping and found areas for improvement. For example, identified gaps included the recording of father's details, children's development and outcome focussed plans. An action plan was developed but progress in accordance with this plan was unclear at the time of our review.

5.2.5 In school nursing, challenging information technology issues had weakened access to a live record that contained children's health needs. School nurses that provided support to children in the community and, in particular, in settings where they provided 'drop-in' services, were unable to view existing information they held about children as they had no access to electronic records. This limited the robustness of assessment of children's needs at that time as those school nurses did not have access to children's records and this also meant that records could not be updated efficiently and contemporaneously. ***(Recommendation: 3.12)***. *Public Health commissioners will also be notified of this finding*.

5.2.6 Standards of record keeping in school nursing were too variable. For example, in one child's electronic health record we found that a review child protection conference report for another child had been uploaded. Whilst staff took quick action to address this at the time of our review, the relevant report could not be found and therefore the child's record was incomplete. Standards in the recording of outcome focussed plans were also varied. When completed, there was too much inconsistency in the quality of those plans which limited tracking progress, in particular if those plans were missing from the child's record.

We could not be assured of quality assurance process by leaders and managers within the service to ensure records were both complete and accurate. ***(Recommendation: 3.13)***. *Public Health commissioners will also be notified of this finding*.

5.2.7 In school nursing, children's protective characteristics were not always recorded. In cases examined, we found that children's religion, ethnicity and first language was sometimes missing from the dedicated part of their electronic patient health record meaning staff accessing those records might not be readily aware of important cultural and religious beliefs and so manages their interactions with those children accordingly. ***(Recommendation: 3.13 as at 5.2.6 above)***. *Public Health commissioners will also be notified of this finding*.

5.2.8 We saw that systems were in place to allow staff within the adult A&E to be able to quickly and easily make onward referrals to social care when concerns had been identified. We saw that the staff 'info-net' contained a wealth of information and advice relating to safeguarding and also had easy to find hyperlinks to both adult and children safeguarding referral forms making them readily available. Clinicians were also encouraged to contact social care teams via telephone to check the receipt of referrals made.

Referral forms were also copied to the BSUHT safeguarding team which ensured that they had effective oversight of cases where safeguarding concerns had been identified. This practice also enabled the safeguarding team to identify trends and unusual presentations and activity. This was then disseminated to the A&E 'practice educator' who could ensure that clinicians and staff received appropriate training to meet identified need.

5.2.9 The lead GP for safeguarding at the Brighton Plus WiC had good oversight of all children and young people who had attended the unit where a safeguarding concern had been identified.

A child protection database included personal information for each child where safeguarding concerns had been identified, including whether a referral had been made to the MASH. The outcomes of referrals where proactively followed up and the database was updated monthly and informed managers of trends within the service.

5.2.10 Clinicians at the WiC did not have access to CPIS. Whilst the registration proforma on arrival at the WiC prompted staff to ask if a child attender was subject to a child protection plan and had a named social worker, there was an over-reliance by leaders and managers on practitioner professional curiosity, parental disclosure, and practitioners proactively contacting children's social care to follow up any concerns where identified.

This limited the opportunity for practitioners to be fully informed when determining the most appropriate action to be taken. ***(Recommendation: 1.8)***

5.2.11 Record keeping in relation to safeguarding children was under-developed within the WiC. For example, flags and alerts on electronic patient records were not always used and the records of children did not always contain the same pertinent information as their parents' records. In one case reviewed, the adult's records clearly documented important safeguarding information that was identified during pregnancy. This information was not however, transferred to the infant's records following the birth despite the family having a named social worker. This was rectified immediately at the time of our review.

The Care UK national safeguarding children policy included a 'screening tool for vulnerable children and young people'. Despite this being a basic tool, and intended to 'screen', there was no expectation by managers for it to be completed for all children attending the unit and we did not see any examples of its completion in any records reviewed. Furthermore, when risk was clearly articulated, there was a lack of analysis by leaders of the impact of risks on children and young people to better inform any decision-making processes. ***(Recommendation: 1.9)***

5.2.12 Electronic client record systems in both the CAMH well-being service and specialist CAMHS was conducive in supporting effective record keeping.

All referrals were processed, triaged and initially assessed on the CAMH electronic client record system. If specialist CAMHS was deemed appropriate, all information from the CAMH system was transferred to the specialist CAMH system by the triage practitioner. This practice reduced the risk of information going missing or not being transferred between systems and further helped to ensure that those electronic records remained complete and not fragmented. The system also served to inform managers of the process.

5.2.13 During our review, we visited both the acute male and female inpatient adult wards and saw that a number of family rooms were designated for children and young people to be able to visit their relatives who had been admitted as an inpatient. These rooms were bright, spacious and inviting.

We also saw that the family rooms were situated away from the main wards to minimise distress to visiting children and were also well equipped with toys and books to make their visit more enjoyable. We were told that a TV and Xbox is soon to be available in family rooms to make the environment more inviting for older children and young people when they visit relatives at the units.

Visits from dependent and associated children were carefully and sensitively observed so that practitioners were able to assess risk and patient's ability to care for the dependents post discharge. Seconded social workers were also aligned to adult wards to support discharge planning and the robust assessment of risk. This arrangement ensured effective oversight and management of risk when a patient was discharged home.

5.2.14 We heard how learning from serious case reviews child safeguarding practice reviews, safeguarding adult reviews and domestic homicide reviews was being disseminated by managers across SPFT which was helping to strengthen safeguarding practice.

The internal safeguarding scrutiny panel was providing a useful forum to scrutinise recommendations arising from serious events and to decide if further learning needed to be offered to practitioners.

We heard how, following a recent case review where two young males became radicalised, adult mental health practitioners had benefited from a workshop to 'Raise Awareness of Prevent' training, and gained an understanding of how mental ill health could increase a young person's vulnerability to grooming and radicalisation.

5.2.15 Both GP practices visited had a safeguarding policy based on the Royal College of General Practitioners Safeguarding Toolkit to support best practice. They both also had GP safeguarding leads in the place to act as a first point of contact for advice and to share safeguarding information with other clinicians at those practices.

5.3 Training and supervision

5.3.1 Specialist midwives in Brighton and Hove had good access to support through the provision of quarterly network meetings. This helped the dissemination of information and updates to other midwives and provided opportunities for reflection on practice.

5.3.2 Although there was no formal one-to-one safeguarding supervision within midwifery services, the established method of undertaking such supervision in groups with peer support and individual case discussion did give the opportunity for practitioners to discuss cases of concern and share suggestions on ways to protect vulnerable expectant mothers and their unborn children. This practice would be strengthened further if cases discussed were subject to more formal documentation, such as within client records with planned goals and outcomes listed along with responsible person's and dates for review. We were later informed that specialist midwives are provided with one-to-one supervision recognising the specialist nature of their work, but it was not clear if this was specific safeguarding supervision or clinical supervision. ***(Recommendation: 2.19)***

5.3.3 Health visitors had good access to one-to-one management and safeguarding supervision. Team leaders provided this every four to six weeks where the caseload would be reviewed and at least two safeguarding cases discussed. Team leaders were also supervised by the named nurse. The named nurse provided 'Healthy Futures' health visitors with bi-monthly group safeguarding supervision. This gave frontline staff dedicated time to focus on complex safeguarding practice and supported their own professional development.

5.3.4 In health visiting, practitioners had received training in criminal exploitation and adverse childhood experiences and could access Brighton & Hove Safeguarding Children Partnership (BHSCP) training over and above the mandatory safeguarding training they were required to attend in accordance with current intercollegiate guidance. New staff were supported into their role by way of set guidelines to help develop their safeguarding practice and this was monitored throughout their probation period to ensure compliance.

5.3.5 In school nursing, we saw good use of a dedicated template to aid safeguarding supervision and discussion of complex cases. This included scoring the level of risk based on the concern highlighted. While actions were appropriate, this process could have been improved making them more specific, measurable and outcome focussed.

5.3.6 School nursing staff had good access to regular safeguarding and clinical supervision. The model used had meant that band six nurses provided safeguarding supervision to band five nurses. The named nurse reported that they had arranged training to develop the supervision skills of some staff even further. However, while we recognised this was positive, greater assurance that this arrangement robustly ensured that band six staff had the necessary expertise and competency to sensitively challenge and develop the safeguarding skills of those they supervised was required although this was recognised at the time of our review.

5.3.7 Clinicians in the paediatric A&E at RACH were benefitting from regular safeguarding supervision sessions. Face to face safeguarding supervision was offered to clinical staff by the safeguarding nurse. Supervision that took place was formally documented. Staff we spoke with told us that appreciated the continual support that they received, both via the formal supervision process and more informally as and when required.

5.3.8 The practice educator had a significant role in the adult A&E, ensuring that all new staff within the unit were appropriately trained in safeguarding adults and children best practice in accordance with safeguarding children and young people: roles and competences for health care staff intercollegiate document, third edition: March 2014.

5.3.9 At the time of our review, only 59% of adult A&E clinicians had received safeguarding children and young people level three training, which was significantly lower than the 90% Trust target. However, we were assured that training figures had been affected by a number of 'new starters' who had yet to receive their formal level three training and were shown that clear plans were in place to ensure that this mandatory training was completed as soon as practicable. During this time those practitioners were receiving close supervision from peers and supervisors to significantly reduce risk.

5.3.10 At the Practice Plus Brighton WiC, not all required topics were included within safeguarding children training, with criminal exploitation and county lines being identified by medical director as a significant gap. This meant that children and young people attending the centre who were at risk from, for example, criminal exploitation might not have their risks identified, assessed or referred for appropriate intervention and protection. ***(Recommendation: 1.10)***

5.3.11 Doctors and nurse practitioners providing care and support to children who attended the WiC did not receive formal safeguarding supervision, either in one-to-one meetings or in groups. Although there was the opportunity to discuss challenging cases at the daily 'huddle' and the monthly clinical meetings, formal safeguarding supervision was not embedded. ***(Recommendation: 1.11)***

5.3.12 The supervision of CAMHS and perinatal mental health practitioners in relation to safeguarding children was under-developed. Safeguarding was an expectation to be included into monthly clinical supervision facilitated by a peer in the same discipline, but the supervision policy did not refer to specific safeguarding supervision.

We recognised that there were opportunities for exploration of risk through monthly complex case meetings. The provision of reflective and restorative, one-to-one safeguarding children supervision provided a safe space for respectful challenge to improve practice. However, the lack of such supervision for case-holding practitioners restricted the opportunity for both them, and leaders to be assured that children and young people were effectively safeguarded. ***(Recommendation: 4.3)***

5.3.13 Multi-disciplinary health professionals across Brighton benefited from bespoke training facilitated by a psychiatrist based within the perinatal mental health team alongside women who had previously used the service.

The training was based on cases experienced with the use of actors to deliver scenarios for discussion. Two of 14 sessions had been delivered at the time of our review and they have been evaluated well but it was too early to fully evaluate the trainings impact.

5.3.14 Within adult mental health, the risk managements we reviewed demonstrated that practitioners were adopting a contextualised approach to safeguarding and considering the vulnerability of adults with poor mental health in a variety of social contexts. Information recorded in risk management plans also denoted exploration of adversity that patients had experienced in childhood and from previous traumas. They also recorded the impact that those experiences may have had on their wellbeing and safety and potentially children and young people in their care.

5.3.15 The supervision received by adult mental health practitioners was inconsistent. We heard for example, that some teams, due to current issues with staffing capacity, did not always have protected time to benefit from supervision and reflective practice.

Whilst there was a Trust wide safeguarding supervision policy in place, safeguarding supervision was not built into the supervisory system. Safeguarding supervision should be available to all practitioners working directly with vulnerable children and adults to ensure that risk to vulnerable adults and children is minimised, outcomes were improved, and organisational risks reduced.

Whilst we recognised that there were a number of ways staff could seek ad-hoc support to discuss complex and challenging cases outside of formal supervision processes, for example by contacting the Trust safeguarding team for advice and consultation, it was not always being documented when case discussions had taken place and what actions should be undertaken. This means that records were not always complete. ***(Recommendation: 4.5)***

5.3.16 Practitioners within the SHAC service were offered comprehensive safeguarding children training. Compliance with the intercollegiate guidance, March 2014 was at 98% during the time of our review, this being inclusive of reception staff which is good practice, as BSUHT had considered non-clinical staff to be integral to ensuring the understanding of safeguarding was well developed across the service.

We also heard how the Nurse Consultant for Safeguarding Children, along with the SHAC safeguarding lead, delivered annual bespoke training to all staff on topical issues in areas where it had been recognised further learning was needed. For example, this year the focus was on criminal exploitation and county lines criminal exploitation. This supported the development of a well-trained workforce across the service supporting the identification of need and safeguarding best practice.

5.3.17 Ru-ok were proactive in offering training to the Brighton and Hove services that offer care and support to young people. For example, DASH workers had delivered training to both GP's and their reception staff to raise their knowledge and awareness of young people's substance misuse. The service also offered free training twice a year to practitioners to increase their knowledge especially linked to issues topical to the area. These approaches were supporting the development of a knowledgeable workforce regarding the impact of substance misuse on young people within Brighton and Hove.

5.3.18 In the Pavilions adult substance misuse service, practitioners were provided with level three safeguarding training even when they did not have one-to-one interaction with children and young people. This was good practice in ensuring that adult service practitioners understood the vulnerabilities of children in the care of adult service users and so were confident in identifying and referring safeguarding concern accordingly.

Recommendations

1. Brighton and Hove CCG should:

1.1 Ensure that systems and processes are implemented to notify public health nurses, including health visitors and school nurses of attendances at the WiC of children and young people who might be in their care with minimal delay.

1.2 Implement effective screening processes for all children and young people who attend the WiC so that vulnerabilities and risks can be better identified and reported.

1.3 Implement effective screening processes for all adults who attend the WiC that investigates their relationships with potentially vulnerable children and young people and ensure that those processes are used effectively by way of regular audit.

1.4 Review and implement policies relating to children and young people who are brought to the WiC but did not wait for assessment or treatment and ensure that children and young people who did not wait to be treated are followed up without delay.

1.5 Explore and implement methods to ensure GPs are routinely notified of the outcome of MARAC meetings, particularly where they have provided information to inform those meetings.

1.6 Implement policies and procedures for practitioners at the WiC to follow when providing care and support to non-mobile infants to ensure risks are identified and acted upon quickly and efficiently.

1.7 Investigate and implement methods to ensure that flags and alerts in GP practices across the area are kept up-to-date and relevant.

1.8 Evaluate and implement methods to reduce the reliance of individual staff professional curiosity at the WiC to ensure potentially vulnerable children and young people are identified and protected and that leaders are made aware of specific and emerging trends within the unit.

1.9 Ensure records within the WiC accurately reflect that risks to children, including unborn children, are considered and acted upon and further that tools are routinely used where risk is identified.

1.10 Leaders must ensure that safeguarding children training is in line with intercollegiate guidance and also that of the BHSCP.

1.11 Ensure clinicians at the WiC who provide care and support to children and young people are provided with formal safeguarding supervision in line with intercollegiate guidance.

1.12 Investigate and implement better methods of engagement between public health nurses and GPs.

2. Brighton and Sussex University Hospitals NHS Trust should:

2.1 Revise pregnancy booking templates to ensure that they contain adequate prompts for practitioners to ensure pregnant mothers and unborn children are kept safe and that their use is monitored for quality assurance purposes.

2.2 Implement effective screening tools and prompts to be used within maternity services to facilitate the identification and recording of incidents of domestic abuse and that their use is monitored for quality assurance purposes.

2.3 Review and improve the use of safeguarding assessment tools at the paediatric A&E to test its robustness in identifying vulnerability and further monitor practitioners use of those tools effectively by regular audit.

2.4 Provide practitioners at the adult A&E with appropriate age-related triage documentation and further that risk screening tools are available for use where risk is identified. This process should be audited regularly to assess its implementation.

2.5 Ensure that prompts are available to practitioners at the point of triage within the adult A&E to help identify potentially vulnerable children in the care of adult attenders who may have undertaken risky behaviours.

2.6 Ensure assessments undertaken by midwives are completed correctly and quality assured regularly and ensure r that appropriate training and guidance is provided to midwives where failings are noted in assessment processes.

2.7 Ensure the availability of tools within maternity services to aid the identification of risk and that they are used appropriately by way of regular audit.

2.8 Continue to recruit to maternity services to improve the continuity of care to families using the service.

2.9 Provide clear advice to practitioners within the SHAC service regarding the recording of interviews with young people, particularly when accompanied by adults and ensure that this is completed by way of regular audit.

2.10 Provide community midwives with opportunities to visit expectant parents in their own homes, particularly where risk might be already identified to allow for assessment of the home environment and ensure that birth notifications are effectively shared with community midwives as soon as practicable.

2.11 Ensure by way of appropriate training, audit and supervision that referrals made to children's social care from maternity services are strong and clearly articulate risk protective factors and required outcomes.

2.12 Ensure information shared and decisions made at MARAC meetings are appropriately recorded in client records by way of regular audit.

2.13 Explore and implement methods to ensure better access to CPIS by practitioners in a timely way including outside of normal daytime working hours.

2.14 Explore and implement better methods for practitioners working within the adult A&E to access important safeguarding information in a more efficient and effective way.

2.15 Ensure continuity in risk assessment processes by way of staff training and effective oversight and audit of the use of provided templates.

2.16 Review and strengthen the role description of the named midwife role ensuring it appropriately recognises and meets the needs of the local population.

2.17 Review and strengthen arrangements for record keeping within both the paediatric and adult A&E to ensure records held are both complete and up-to-date.

2.18 Expedite progress to ensure record keeping within maternity services is less fragmented and that records are complete at all times.

2.19 Strengthen oversight of individual safeguarding risk to ensure planning, goals and outcomes are better recorded and adhered to within agreed timescales.

3. Sussex Community NHS Foundation Trust should:

3.1 Assess and improve the availability, quality and use of risk assessment tools within the school nurse service and continue to monitor their effective use by regular audit.

3.2 Investigate and implement better methods of engagement between public health nurses and GPs.

3.3 Explore and implement methods to ensure continuity of information sharing between public health practitioners and GPs so that care and support is provided in continuity between each service.

3.4 Ensure that enquiry regarding domestic abuse takes place routinely as part of the healthy child programme or whenever risk might be suspected. Also, ensure by way of regular audit that such enquiry is recorded and forms part of an agreed safety plan where necessary.

3.5 Revise the use of chronologies within public health services and ensure that significant events are appropriately recorded within dedicated templates available. Where complex families are identified then the use of chronologies should form part regular contact between practitioners and clients and they should be monitored by regular audit.

3.6 Expediate plans to ensure children currently missing from education are identified to school nurses by way of strengthened links to the local authority.

3.7 Ensure that information is shared between health visiting public health and the MARAC, that outcomes are appropriately recorded in client records, that alerts are placed on those same records where risk is identified and that the process is monitored by way of regular audit.

3.8 Ensure that advice and training is provided to school nurses to ensure that referrals made to children's social care contain relevant and important information to better inform the decision-making process. This should be monitored by more stringent quality assurance.

3.9 Implement methods to ensure that risks to unborn children of adult mental health service users are both considered, assessed and recorded appropriately in client records and further go on to inform effective safety planning. The process should be the subject of regular audit.

3.10 Review and implement better methods of record keeping within health visiting services to ensure records are complete and accurate. Ensure best practice is adhered to by way of regular audit.

3.11 Undertake more accurate data recording within adult mental health to provide a better understanding of potentially vulnerable children in the care of adult service users.

3.12 Explore and implement methods to ensure that school nurses have better access to children's records during their interactions with them.

3.13 Review and implement better methods of record keeping within school nursing to ensure records are complete and accurate and also ensure best practice is adhered to by way of regular audit.

4. Sussex Partnership NHS Foundation Trust should:

4.1 Ensure that systems support the effective sharing of information with GPs regarding children and young people receiving care and support from CAMH services.

4.2 Implement methods to ensure that referrals made to children's social care are appropriately recorded on client records and that this practice is subject to regular audit.

4.3 Ensure that safeguarding children supervision is equitable across the CAMH service for all practitioners who might work closely with vulnerable children and young people.

4.4 In association with commissioners, review and implement dual diagnosis practice and ensure that a protocol is in place advising staff of their roles and responsibilities when providing support to people across both disciplines.

4.5 Ensure that formalised safeguarding supervision is embedded into practice across adult mental health services and that when formal safeguarding supervision takes place this is recorded appropriately.

5. Brighton and Hove CCG and Brighton and Sussex University Hospitals NHS Trust should:

5.1 Explore and implement methods to better ensure that GPs, as primary record holders, are more effectively and efficiently notified of young people's attendances at the adult A&E.

6. Brighton and Hove CCG and Sussex Community NHS Foundation Trust should:

6.1 Must expedite methods to improve the timeliness of IHAs and that this is supported by a timely plan of action with clear objectives and timescales.

6.2 Methods for conducting IHAs in line with current guidance must be explored and implemented in an expedited way to ensure that those important assessments are undertaken by appropriately trained and supported practitioners.

6.3 Ensure appropriate oversight is maintained and training provided where required to ensure that all practitioners undertaking RHAs do so accurately and in a timely way.

6.4 Expedite a review and decision as to current arrangements for undertaking IHAs in line with current best practice guidance.

Next steps

An action plan addressing the recommendations above is required from NHS Brighton and Hove CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.