

**Review of health services for
Children Looked After and
Safeguarding in Kent
(Communities served by West
Kent, Swale, and Dartford,
Gravesham & Swanley Clinical
Commissioning Groups)**

Children Looked After and Safeguarding The role of health services in Kent

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Provider services included:	Maidstone and Tunbridge Wells NHS Trust Dartford and Gravesham NHS Trust Medway NHS Foundation Trust (<i>in relation to services provided to children, young people and families living in Swale</i>) Kent Community Health NHS Trust Sussex Partnership NHS Foundation Trust Kent & Medway NHS and Social Care Partnership Trust
CCGs included:	NHS West Kent CCG NHS Dartford, Gravesham & Swanley CCG NHS Swale CCG
NHS England area:	South of England
CQC region:	South
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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 North and West Kent. 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 NHS England Area Teams (ATs).

Where the findings relate to children and families in local authority areas other than North and West Kent, 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 2013.

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 130 children and young people.

Context of the review

Kent is a shire county located in the south east of England. According to the 2011 Census data, Kent has the largest population of all English counties. Over the last ten years the population has grown faster than the national average, with future forecasts predicting an increase of over 10% by 2026. The age profile shows a similar picture to that of England although Kent has a greater proportion of younger people aged 5-19 years. Parts of Kent share the affluence of the south east of England region and, overall, Kent ranks as the 51st least deprived local authority. However, some areas of the county are amongst the most deprived in the country. While almost three-quarters of the county is rural, most people live in the main 26 towns, the largest of which is the county town, Maidstone.

Kent's population is largely of white ethnic origin and the largest ethnic group of looked after children is white British accounting for nearly 85%. 15% of school children are from a black or minority ethnic group.

On the whole the health and well-being of children in Kent is variable compared with the England average. The infant mortality rate is significantly better and the child mortality rate is generally in line with the England average, although the West Kent CCG reports that there are higher than average rates of child death in the Sevenoaks and Maidstone areas. In 2011- 12, the rate of emergency department attendances for children under four years of age, and the rate of hospital admissions due to injury for under 18 year olds was significantly better than the England average. The rate of hospital admissions as a result of self-harm in that period was generally in line with the England average, although the rate of hospital admissions for mental health conditions was significantly worse.

In 2012, the conception rate for under 18 year olds per 1000 females in Kent was in line with national averages although West Kent CCG notes that there are pockets of high teenage pregnancy rates in some areas. The percentage of teenage mothers in the county, and rates of breastfeeding initiation are significantly worse when compared to the national average.

A higher percentage of children (94.4%) have received their first dose of immunisation by the age of two in this area than the national average, and similarly a higher percentage of children have received their second dose of MMR immunisation by the age of five (90.5%).

The proportion of Kent's children who are obese is better than the average level, with 8.7% of children aged 4-5 years classified as obese. However, only 54.1% of children participate in at least three hours of sport a week which is worse than the England average. In comparison with earlier statistics, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose has decreased in the 2008-11 period. Overall rates of admission in the 2008-11 period are lower than the England average

The looked after children population has increased by 25% since 2010 (as of March 2013), and numbers are above that of other regional comparators. This includes a high number of unaccompanied asylum seeking children (UASC), approximately 10% of the looked after children population. In 2013, 92% percentage of children looked after had their immunisations up to date which was significantly better when compared with the England average. 84% of LAC had their teeth checked by a dentist. 84% received their annual health assessment and 96% of looked after children who were aged five or younger had up to date developmental assessments.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Kent in 2013. The average score per child in was 15; although this average score has slightly decreased since 2012, this score is considered borderline cause for concern.

There are three clinical commissioning groups (CCG) operating within the area covered by this review: NHS West Kent CCG, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG. Commissioning and planning of most health services for children are carried out by the CCGs supported by Kent and Medway Commissioning Support Unit (KMCSU), which is hosted by NHS England.

Acute hospital services are diverse across the area we reviewed:

- In the West Kent CCG area, there are two acute hospital sites provided by Maidstone and Tunbridge Wells NHS Trust – Maidstone hospital and Tunbridge Wells Hospital at Pembury (known as Pembury hospital). Both hospital sites have emergency departments for both adults and paediatric attendances, although there are no separate paediatric treatment facilities at Pembury. There are paediatric in-patient services at Pembury, with a paediatric day service at Maidstone hospital. Pembury hospital has maternity services including a postnatal ward and a neonatal unit offering intensive care, high dependency and special care for preterm and sick new-born babies, and there is a standalone midwifery led birthing centre located in the grounds of Maidstone hospital.
- In the Dartford, Gravesham and Swanley CCG area, acute hospital services are provided by Dartford and Gravesham NHS Trust. The Trust has three locations registered with the CQC, although only the service based at Darent Valley hospital was included in this review as the other two are located in a different local authority area. Darent Valley hospital has an emergency department with separate adult and paediatric facilities; in-patient paediatric services including a 5 bedded paediatric assessment unit; and maternity services including neonatal and special care facilities.
- For residents in the Swale CCG area, acute hospital services are provided by Medway NHS Foundation Trust at Medway Maritime Hospital. This hospital site also has an emergency department with separate adult and paediatric facilities; community and in-patient paediatric services including a paediatric assessment unit; and maternity services including neonatal and special care facilities

Commissioning arrangements for looked after children's health are undertaken by Kent & Medway Commissioning Support Unit. The looked-after children's health team designated doctor roles, as well as the operational looked-after children's nurses are provided by Kent Community Healthcare Trust (KCHT).

KCHT also provides a range of community health services, including seven Minor Injury Units across Kent. The Trust provides health visiting services across all of Kent. In addition, across all three CCG areas, child and adolescent sexual health services are commissioned by Kent County Council Public Health (KCC PH) and provided by Kent Community Health Trust (KCHT).

School nursing is also commissioned by KCC PH across the three areas reviewed, but provided by Medway Foundation Trust in Swale and by KCHT in the other two CCG areas.

Child and Adolescent Mental Health Services (CAMHS) at tiers 1- 2 (emotional well-being and support delivered within universal settings) are commissioned by Kent County Council Early Intervention Service (joint funded with the CCGs). Services are provided by Healthy Young Minds, a consortium of organisations. Tier 2-3 services (targeted and specialist support) are commissioned by the CCGs, with West Kent CCG having a lead commissioning role, and are provided by Sussex Partnership Foundation Trust (SPFT). Specialist CAMHS services for looked after children are commissioned by Kent County Council and provided by SPFT. Tier 4 specialist in-patient CAMHS services are commissioned and funded by NHS England and provided by the South London & Maudsley NHS Trust (SLAM) across Kent.

Adult mental health services are commissioned by the CCGs and provided by the Kent & Medway NHS and Social Care Partnership Trust (KMPT) across Kent. This includes an early intervention in psychosis service for people aged 14-35 years old, and MIMHS – a mother and infant mental health service.

KCA (drug and alcohol and mental health services) provide child substance misuse services commissioned by KCC PH. Adult substance misuse services are commissioned by Kent Drug & Alcohol Team and provided by CRI (Crime Reduction Initiative) service

The last inspection of health services for Kent's children took place in October 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

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

People attending an emergency department minor injury department told us:

"I feel quite happy with the MIU service and how we have been dealt with. We've been waiting about 20 minutes but we were told there was a wait, so it is fine." – [a parent attending with their child]

"It's alright. I'm happy with the service so far. The receptionist did ask who had brought me today." – [young person]

Parents attending an emergency department with their child told us:

That they had been advised that there would be a three hour wait, and had been kept fully informed about what was happening. They had not been shown the children's waiting area but were in the main (adult's) waiting area. They had no concerns about the care that their child was receiving

Parents whose children had used child and adolescent mental health services told us:

"The psychiatrist we have now for my son who has Asperger's is the best we have ever had. She has really connected with him and I cannot fault the service. When things got really critical lately she saw him in her lunchtime as there were no appointments available. She supports the family too and has been a godsend"

One parent told us that the initial assessment at the emergency department was distressing, *"we felt like we were inconveniencing her [the CAMHS out of hours worker]"*, but then their daughter was admitted to the hospital and assessed the same day by a different worker who *"seemed very helpful, excellent"*. Their daughter was referred very quickly for counselling – *"a lovely lady, a diamond, couldn't fault her in any way."* Their daughter stopped harming herself, and *"started talking to me"*. Therapy is now ended – *"the job's now done, she's a lot better now"* but *"if we need anything, we can just come back through the therapist"*.

Young people who were looked after or care leavers told us:

- *“They do check whether you are healthy, height and weight wise. It was quite useful”*
- *“I found the health assessment quite thorough and quite in depth. I was given some information which was age appropriate”*
- *“I had the same nurse for a few years. She did get to know me but the health reviews still weren’t connected and felt like just a snapshot”*
- *“When I met with the doctors, they were more thorough than the nurse”*
- *“The health review told me everything I needed to know. My height and weight. It was okay”*
- *“I should have been given a choice about where the health review happened”*
- *“I had a health assessment just once in three years with the nurse. She told me I was obese and told me to sort it out myself.”*
- *“They just tick boxes”*
- *“We have to look things up our selves. I have used the local sexual health clinic but we have to find it ourselves and they are not really there to advise us.”*
- *“I had a good experience when I went to the sexual health clinic. I was confident that the conversation was private and staff were friendly.”*
- *“There was no discussion of sexual health at my health review even though this would have been helpful.”*
- *“The nurse comes to see me. It confuses me because she gave me the chance to see her alone which I wanted as I needed to share problems I was having. Then she called my foster carer in and told her everything. I felt let down.”*
- *“The foster carer was with me the whole time. I wasn’t given a choice”*
- *“Care leavers should still have the option for a health assessment but we don’t get any information about having to pay for dental treatment or opticians”*
- *“As a care leaver, I wasn’t given any health history, no record of my immunisations. I had to find that out for myself from my doctor later.”*
- *“As a care leaver, I should have a clear last health review before leaving care. I should leave with my health history. It is important. My foster carer helped me sort out what health information I needed when applying for jobs”*
- *“When I was 18 I found out my immunisation records from my GP myself”.*

Young people waiting to access contraception and sexual health services told us:

- *“(One CASH nurse) is lovely; she is helpful and non-judgemental.”*
- *“They need more nurses, if you get here after school it is usually busy and they often send you away.”*
- *“[One] receptionist is really rude and when you whisper what you want she shouts it back at you and everyone can hear.”*

Young people at a centre for unaccompanied asylum seeking children told us:

- *“It’s ok at the centre, I feel safe”*
- *“The staff are the best thing about being at the centre”*
- *“I saw the doctor after about a week of being here as I had some health issues. He spent a lot of time with me and it was very helpful. He referred me for a scan and to see a specialist.”*
- *“I felt the doctor explained everything to me. He asked about my experiences and my parent’s health”.*
- *“I would like more physical activity at the centre. We tried to play football in the small courtyard but were afraid of breaking the windows”*
- *“I would like to go to the gym and to go swimming. I do go out for a walk and play pool.”*

One parent told us:

“My health visitor is the best” but that *“no-one else cared”*. *“I was left to cope on my own”* after the birth until seeing the health visitor who asked about her mental health and *“had time to listen. She listened to my concerns. She was the only one asking”*. The health visitor is now arranging for a meeting to arrange help and support for this parent.

One foster carer told us:

“There is good access to training and support. I’ve done all of the courses and I’m doing a degree now. I get information on [the young person’s] health and how to manage it”. Art therapy was offered but the family were able to *“wait til the right time to have this – wait for her to be ready. She is now engaging well, she likes it, it’s totally her choice”*. *“Everything’s been fine, but I had to be active, if I’d sat back and waited maybe things wouldn’t have happened”*.

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 Across the midwifery services that we visited in Kent, there were robust systems in place for staff to take comprehensive family histories from pregnant women. This means that social factors are routinely assessed alongside medical presentation in allocating the level of care and support needed throughout the mother's pregnancy. Templates and forms used for assessment that we saw had good prompts to record medical history and partner details as well as concerns and vulnerabilities. In Medway Maritime Hospital, the family background questionnaire used explores the existence of other children either in the family, or who may have been removed, as well as other potential complex social factors that may influence the level of support that a pregnant woman may require to safeguard herself and the unborn child. We were told that this form was also in use at Maidstone and Tunbridge Wells This is good practice.

1.2 Midwives are routinely contacting GPs when women self-refer, to alert them of the pregnancy and request relevant information. Across the Maidstone and Tunbridge Wells Trust (M&TWT), easily identifiable pink forms are sent to the GP for completion enabling the midwives to gather relevant information to support their comprehensive risk assessment. This is good practice, although we identified that this could be strengthened further by explicitly asking the GP to include any concerns that they may have concerning parenting capacity [*recommendation 1.1*]. Midwives across the area report variable communication from GPs although we saw examples of good communication and liaison in the cases that we reviewed. In some localities midwives are linked to specific GP practices, holding regular clinics in surgeries which improves access for parents and promotes more robust joint working. In the West Kent area, home visits by midwives have recently been introduced for women for whom risks are identified, although this is not yet embedded in routine practice.

1.3 There are specialist midwifery roles and clinics for vulnerable women including those with mental health and substance misuse problems. Across midwifery services, we saw examples of very good care and practice for vulnerable women who were pregnant, including one exemplary case of peri-natal care and birth planning for a woman with mental health problems in the Swale area (Medway Maritime hospital).

Case Example: *a mother to be had a history of severe mental health issues, which she discussed at booking with the midwife. The mother also told the midwife that she had stopped taking her medication, and stopped alcohol and drug use. A referral was made to the local peri natal mental health service, to the substance misuse services and also a safeguarding letter was sent to the GP asking for additional information. A full family background information form was completed and a mother and infant mental health service post natal care plan was created. The care plan comprehensively identified all potential risks and actions to mitigate and care for the mother and baby at birth and in the post natal period and supported and safeguarded both mother and baby effectively.*

1.4 There is an effective and highly valued mother and infants service (MIMHS) provided by the adult mental health trust. The only exception to this being Dartford and Gravesham NHS trust where mental health provision is only provided via existing maternity services resources. This team actively works with community mental health teams and health visitors to identify pregnant women with mental health problems and to promote joint work including joint assessments. However, the criterion for the service requires the mother to have a diagnosis or be eligible for secondary services. The application of diagnostic criteria creates missed opportunities for preventative work to be done or early support provided. Learning from national serious case reviews and incidents highlights the significance of timely care for mothers focusing on the prevention of mental health problems developing or escalating in order to minimise risk to them and their children [*recommendation 2.1*]. We heard from one mother with mental health problems who felt that services had not offered her enough support until after the birth, when the health visitor had done a thorough assessment and was now arranging for a meeting to try to provide more support for her. We were pleased to hear that 12 new peri-natal mental health visitors have been appointed who will provide more intensive support to mothers with mental health problems, although these had not yet started work at the time of this review.

1.5 We heard some concerns about the availability of support for teenage pregnant women. The family nurse partnership programme is targeted at specific areas with high rates of teenage pregnancy, which creates some inequity of access. However, commissioners reported that action is being taken for the programme to be extended imminently, following clarification of funding arrangements, which is a timely and welcome development.

1.6 Information sharing between midwifery services and other health and social care professionals, particularly at initial stages of pregnancy and booking, is good although the arrangements for this varied across the services that we visited. In some areas there are regular team meetings to discuss cases with health visitors which facilitates effective joint working and information sharing to identify cases, and to support care planning where additional early help or safeguarding assessment may be needed. Multi-agency maternity liaison meetings have been initiated in Swale and early indications are that this is facilitating improved access to early help but these meetings do not happen in the other areas, [*recommendation 3.1*]

1.7 Health visiting services have experienced significant challenges in recruitment and retention of staff, reportedly largely due to competition with neighbouring areas. Progress has recently been made with recruitment and sufficient health visitors have now been recruited under the national 'Call to Action' to enable a specific health visitor to be allocated to each GP practice and children's centre. In addition we were told that during 2013/14 Kent Community Health Trust achieved one of their Commissioning for Quality and Innovation (CQUIN) targets by stating each month which health visitor was linked to each GP practice. During our review we found that not all of the GPs were able to identify who their allocated professional was, or to determine the impact of the new arrangements. Where contact has been made, GPs report very good communication. Regular meetings to share information about families and children of concern are highly valued in the identification of risk, enabling enhanced support and early help to be provided.

1.8 This recent progress in recruitment is also beginning to underpin improvement in the delivery of routine health visiting services across the areas that we visited. We found significant variation across teams in respect of undertaking pre-birth home visits for vulnerable women and in carrying out developmental checks. In Swale, the impact of this has been recognised and there is an action plan in development to improve consistency. In West Kent teams, health visitors are re-introducing home visits as part of the core offer. Across all areas, larger teams and a newly introduced corporate approach is having a positive impact on case load management and addressing inconsistencies and inequalities in service delivery.

1.9 A robust policy is in place across midwifery and health visiting services to follow up mothers and children where appointments are not attended, including escalation through to safeguarding in persistent cases. We saw evidence of diligent follow-up in a number of cases where parents failed to attend appointments.

1.10 Capacity across school nursing is stretched and practitioners reported that "*covering the basics is a challenge*". There is significant variation in the types of service delivered by individual school nurses who are currently operating in small locality teams. A planned re-configuration of the service into larger, more centrally based teams is intended to aid consistency in service delivery and reduce inequalities across the area.

1.11 Positively, all GPs practices have been offered the opportunity to meet with school nurses on a regular basis to exchange information, with approximately half of practices taking up this offer. Some practices have established quarterly "communication meetings" which include the school nurse, health visitor and social workers. Practitioners reported the benefits of this joined up working saying "*it makes such a difference knowing them, then things get actioned by people really quickly*". School nurses now also offer a "marketplace" event in schools to promote health awareness and a mobile text service for young people to contact them directly. We saw examples of school nurses following up on concerns leading to effective early help for young people. In one case seen, the school nurse displayed a flexible and approachable attitude in following up health concerns outside of the usual appointment locations in order to meet parent's needs. In another case, concerns raised by parents at a school nurse drop-in clinic led to the family accessing appropriate support for their child who had autistic spectrum disorder.

Child “D” was reluctant to engage with the school nurse and other health professionals. The school nurse demonstrated a determined and persistent approach in trying to engage “D” over an extended period of time. Once she had built rapport with “D”, the school nurse facilitated her engagement with the GP and the CAMH service. The school nurse supported “D” by helping her communicate fears around confidentiality and information getting back to her parents about family background issues

1.12 However, record keeping that we saw was underdeveloped across health visiting and school nursing records and did not support needs-led assessment and care delivery. Recording in health visiting predominantly consisted of comments reflecting interaction with parents, and across both services there was no clear link between assessment, care plans and health visitor activity. Although some good individual cases were seen, too frequently records did not reflect or underpin best practice. Some family assessments were not thoroughly completed, and most care plans were not comprehensive, child-focussed, specific or measurable , [recommendation 4.1]

1.13 Contraception and sexual health (CASH) services are provided by Kent Community Health NHS Trust. Specialist outreach teams work across Kent and support vulnerable young people through individualised packages of care, advice and support including sessions on self-esteem, body awareness, and relationship issues. These are effective and highly valued by the young people using the service. Access to emergency contraception is good, with all walk in clinics, minor injury units and accredited pharmacists able to dispense tablets. Young people that we met gave positive feedback on the service, although some identified concerns about lack of respect for their privacy in reception areas. Young people were also concerned that at times the service is busy and they are not always seen the same day. Despite the CASH service developing a smart phone application to inform people where and when the CASH clinics are open, the young people we met did not know where to go if they needed contraception or advice if they were unable to attend their local session or if they needed emergency contraception, which may deter them from getting a timely service to meet their needs.

1.14 There are effective systems across the four hospital emergency departments that we visited to support staff in the identification of risk factors indicating that children who attend for treatment are vulnerable or may need extra support or referral to early help services. Electronic flagging systems identify those young people who are subject to a child protection plan, or who have had multiple hospital attendances. At Darent Valley hospital, young people with ten or more emergency department attendances are automatically reviewed by the consultant paediatrician responsible for safeguarding. This is good practice and supports early identification of concerns. However, the identification of children looked after was not included in the flagging system across Maidstone and Tonbridge Wells Trust, which means that the health needs of this more vulnerable group, who are more likely to have poorer health experiences, may be overlooked, [recommendation 1.2]

1.15 At the emergency department at Maidstone hospital, we saw there was a flagging system for children and unborn babies with a child protection plan in place for unborn which would flag up on the mother's profile. This means pregnant women attending the emergency department needing more specialist intervention would be identified, which supports positive outcomes for these women. In Darent Valley hospital trust, gynaecology services operate an early pregnancy unit (for women under 16 week's gestation) and maternity triage unit (for those over 16 weeks). This means that women receive specialist advice and support rather than having to present at the emergency department, which enhances the quality of service to them.

1.16 All emergency departments and minor injury units (MIUs) routinely send notifications of attendance of children and young people to GPs, health visitors and school nurses. Health professionals confirmed that they did receive notifications, which supports good health assessment and continuity of care.

1.17 All letters generated at the Maidstone and Pembury emergency departments are reviewed by the safeguarding team prior to them being sent out to GPs and community health staff. This is good practice ensuring that all pertinent information is included about any identified support needs, safeguarding vulnerabilities or follow up action required. Where the safeguarding team identify priority actions to be taken, letters are sent immediately to the relevant practitioner by secure e-mail.

1.18 We observed some sensitive and effective interaction between practitioners and people attending emergency departments for treatment. At Pembury, we observed good registration practice, with receptionists engaging directly with children when appropriate to ask who was accompanying them. At Darent Valley Hospital, staff demonstrated a good understanding of the needs of 16/17 year olds who present and need to access paediatric staff. At Medway Maritime hospital, we observed a 16 year old young person who was being treated for some superficial cuts. The nurse treating the patient was sensitively discussing the planned treatment and obtaining their views and consent as to the proposed plan of care.

1.19 Across Darent Valley, Pembury and Maidstone hospitals, there are good and effective arrangements for oversight by the paediatric liaison worker in screening attendances of all young people under eighteen at the emergency departments, and identifying cases where there are concerns about children and young people. The role is effective in ensuring that child protection and early help issues are identified and responded to. We saw examples at Darent Valley hospital of extremely good practice in identifying the need for early help, including the liaison worker identifying the need for continence training for a young child, and an ambulance worker flagging concerns about possible neglect.

1.20 Where paediatric liaison workers made daily visits to emergency departments and in-patient wards, this was felt by staff to enhance safeguarding awareness and improve discussion about early help and child protection issues. Practice varied across hospitals in relation to whether liaison workers had regular meetings with staff to discuss cases and give feedback on good practice or areas needing development. Where there are no formal scheduled meetings within the emergency department to explore and share safeguarding issues in detail and to celebrate good practice, this creates missed opportunities to develop practice and promote learning, [recommendation 7.2]

1.21 Generally, practice across all minor injury units in undertaking comprehensive assessments was impressive, helping the identification of additional support needs and early help.

A 52 year old female attended a minor injury unit with back and neck pain. The nurse practitioner carried out a full nursing assessment and identified that the woman was a single mother with a 12 year old child who had been left at home playing with an older friend. As the mother needed to be admitted to hospital as an emergency the nurse made contact with a neighbour who was a key holder and confirmed that he would be contacting children's social care as more long term arrangements needed to be made. The electronic notes indicate good, contemporaneous notes with details of contact numbers and names of people spoken to. The mother was reassured that appropriate arrangements had been made to keep her child safe whilst she received in patient care.

1.22 There are varying arrangements and facilities across emergency departments in respect of the treatment of young people aged 16 and 17 years. Some paediatric wards will take admissions of young people up to age 18 while in other hospitals young people over 16 are admitted to adult general wards. While this may be appropriate to the young person's needs and choice in some instances, it is not ideal. Particular concerns were identified across emergency departments when young people in this age range attended with self-harm or acute mental health issues. We heard that these young people are usually assessed by CAMHS staff, a service that is provided by Sussex Partnership Foundation Trust (SPFT). Local SPFT CAMHS teams provide a response during office hours, and SPFT operate a separate cross-county out of hours team at other times. Staff at emergency departments across different hospital services reported variable experience of access to, and response from, the service provided by SPFT. It was reported that the out of hours team provided a more timely and responsive service, and we heard examples of experiences of staff who found this valuable and effective. Staff at Maidstone hospital also had daily access to advice up to midnight, which was valued. Generally staff described more significant challenges in accessing a timely response from CAMHS during 'office hours' [recommendation 5.1].

1.23 We heard that young people presenting with deliberate self-harm are routinely offered an admission to a general paediatric or adult ward. This is not supported by an agreed deliberate self-harm pathway which would clarify service expectations and underpin consistency of practice, although we were informed that a Kent-wide pathway is under development. Where a young person who needs support for acute mental health problems or to protect their safety is admitted to a general ward, SPFT make arrangements for additional specialist nursing input to support them and to provide supervision and monitoring. However, these general wards are not age appropriate or equipped to meet the immediate mental health needs of this vulnerable group of young people. The lack of alternative appropriate facilities for young people with mental health problems, especially at “Tier 4” (intensive and specialist in-patient services), is resulting in long stays which risks impacting negatively on them as well as the care of other children. There is insufficient alternative provision locally, and this has at times meant that practitioners struggle to provide an appropriate package of care. Positively, SPFT has recently established a Home Treatment Team within CAMHS to strengthen the emergency response for young people with acute mental health needs, and it is intended for the team to act as an effective diversion from hospital which will ease some of these pressures. While some examples of effective intervention from this team were seen, it is too soon for improved outcomes to be evidenced. The problems are clearly understood by both providers and commissioners, and Tier 4 arrangements are under review by the commissioning body, NHS England. However, the outcomes and impact for service development are not yet clear and the situation for young people requiring high levels of support needs to be monitored to mitigate risk in the interim (*recommendation 5.2*).

1.24 In addition, we heard that there are significant problems in accessing a section 136 ‘place of safety’ bed for young people in Kent. Although a care pathway for young people attending emergency departments and detained under Section 136 has been produced and is welcomed by emergency department staff, this does not clearly set out the pathway for young people who are not detainable and who attend the department by ambulance or as a self-referral. Action that is being taken to arrange access to Section 136 beds within the Kent area is expected to be confirmed imminently. However, this is an interim arrangement to relieve significant and urgent demand, and careful planning is needed to ensure its suitability in the short term as well as to identify appropriate longer term arrangements, [*recommendation 5.2*].

1.25 Tier 3 CAMH services (specialist community children and young people's mental health) have undergone significant change and reconfiguration since being taken over by Sussex Partnership Trust in September 2012. The journey of the provider in addressing challenges and its difficulties in providing an effective service have been clearly and publicly recorded in health overview and scrutiny committee meetings and local media. Teams have been organised into 'hubs' across Kent, with the West Kent hub providing the service across most of the area included in this review. This team has experienced long-term recruitment issues, and is currently holding a number of vacancies across clinical as well as administrative posts. SPFT has focused on improving staffing levels over a period of time, and recent successful recruitment means that the majority of these are due to be filled over the next few months. However, the team has had limited capacity to be able to respond to diverse service demands, and there has been a lengthy period where young people have had extensive waits for initial assessments and to then access services. A range of stakeholders were concerned about difficulties in accessing CAMH services and on the impact that this had on young people waiting after a referral was made. In addition, a range of health practitioners expressed frustration about not being able to refer directly to tier 3 CAMHs, as referral through GPs can create delays and undermine information sharing. Timely access is undermined by lack of a clear pathway or single point of access or triage for CAMHS that would support young people through promoting timely decision making or for sign-posting to alternative services where they do not meet the threshold for a specialist service.

1.26 These diverse problems in the delivery of mental health services to children and young people are clearly understood by both providers and commissioners of mental health services. Overall, an intense focus from the CCGs on performance and management across the service has led to clear evidence of an improvement in service delivery. Treatment waiting times are slowly improving and recently more than half of young people referred to CAMHS have been seen within four weeks and urgent cases seen within 72 hours. However, the legacy of long waits and perceived high thresholds or lack of response to referrals by CAMHs has led to a lack of confidence across a range of other health professionals who have yet to experience the impact of recent service improvements. We saw a number of cases across health services where referrals to CAMHs had not been made due to the deeply embedded lack of confidence that a referral would secure a service. This is a significant challenge to the CAMHS, but it impacts on young people who are not being given an opportunity to access much-needed support and therapy. Much work remains to be done to improve practitioner confidence in the service [recommendation 5.3].

1.27 Where young people do receive a service from CAMHS, this is highly valued and we saw several examples of intervention by the team having positive outcomes for young people's mental and emotional health and well-being. We also heard positive comments from the families of young people who had accessed services recently.

1.28 The learning disability team that previously only covered the south and east of Kent has been extended across the county. Work is currently underway to develop clearer care pathways for young people with neurodevelopmental disorders, i.e. attention deficit hyperactivity disorder (ADHD) and autistic spectrum conditions. This will provide an improved service and reach a wider number of young people. This is to be welcomed although it is too early to have had an impact on outcomes for young people and their families.

1.29 Within adult mental health services provided by the Kent and Medway Partnership Trust (KMPT), there has been strong leadership and active work to promote awareness of and develop systems to support the “Think Family” approach. A programme of training and awareness raising by named safeguarding leads to teams has been undertaken to promote recognition of the needs of children and young people who are in contact with adult mental health service users and to raise awareness of early help options. This has been based on substantial case audit which is intended to ensure that training is embedded into practice. However, the audit process has identified that has yet to secure the change in routine practice and staff culture across the service that had been anticipated by lead staff. Cases were seen where detailed assessments had been undertaken that included reference to children and young people, but this had not led to a relevant care plan. Current IT systems do not support change in practice by providing prompts or automatic links to care planning, [recommendation 6.1]. A rolling programme of targeted intervention by named safeguarding leads to teams continues to be a high priority. There is no effective alert system on the RIO system which means that assessment and care planning could be undermined due to lack of awareness of relevant issues, [recommendation 6.2]

2. Children in need

2.1 A recent emphasis across Kent on improving multi-agency use of the common assessment framework (CAF) in order to identify needs and access to early help services has had an impact. Awareness of CAFs across health professionals is improving, and cases were seen where CAFs had been initiated to good effect.

Case Example: *A young mother to be attended the maternity services at Darent Valley hospital. The concerns and vulnerabilities form clearly documented additional needs and concerns, and a plan was in place to ensure that the mother and baby were supported and monitored. The information on this form was used as the basis of a CAF, and a referral made to social care clearly articulated the risk to both the mother and the unborn baby.*

Staff followed hospital policy when the mother did not attend appointments, and promptly contacted the GP and health visitor to inform them of their concerns. Clear written flagging alerts were in place in the notes to ensure staff were aware of the concerns, and in this case to ensure the baby would not be discharged with the mother while arrangements were being made to assess the situation.

2.2 However, the use of CAFs was not yet fully embedded across all health practitioners. GP's understanding of the CAF was inconsistent, and there was some concern that initiating a CAF meant that they were committed to attend core group meetings, which they felt they did not have the capacity to do. This may lead to underuse of CAF which could undermine access to effective early help for vulnerable families [recommendation 3.2]. Some community staff described challenges in being able to access e-CAF, [recommendation 3.3]. We also heard some concerns about the quality and impact of CAFs, particularly relating to the perceived inequality of access to services, for example enuresis services. We heard about health visitor's concerns about the lack of support for families in the Swale area. One person said, "The CAF is brilliant... but where do families get support?", [recommendation 2.4].

2.3 Kent LSCB has recently provided training to health staff on jointly agreed thresholds for accessing services including for children in need. Thresholds are published and staff demonstrated awareness of this.

Case Example: *Parents of a new born baby "A" both have learning disabilities, and need a lot of support to parent baby A effectively. The midwife considered making a referral for an assessment under the common assessment framework (CAF) which would help identify support for the family. However, her assessment indicated greater levels of concern and that support was needed at a higher level, so a safeguarding referral was made. An initial child protection conference was held. The midwife also took action to secure effective early help for the family by arranging all antenatal visits to be undertaken at the children's centre. This was effective in helping the parents to develop a trusting relationship with the children's centre at an early stage and facilitated the likelihood of effective on-going support.*

The outcome is that Baby A is currently on a child protection plan and the family is being monitored closely with significant support from health visitor and the midwife. Positive progress is being made, and baby A is thriving

2.4 All health professionals use risk assessment processes that would elicit good, detailed family background that could be used as the basis of a CAF or referral to children's social care services. However, while we saw examples of excellent assessments which clearly articulated risk and had informed referrals, these are not the norm and in several cases, referrals from health professionals did not clearly convey the risks. This could mean that referrals would not secure the services and support that the families and children need, [recommendation 3.4]

2.5 We saw examples where the engagement of health professionals in child in need (CIN) meetings led to good co-ordinated working supporting positive outcomes for families and children. For example, developing creative strategies when mothers are reluctant to engage with services, and cross-checking and sharing information when they do not attend for appointments. We saw evidence of good liaison and clearly documented handover between health visitor and school nursing team in a case of a child with a CIN plan. The school nurse regularly checked attendances at a range of medical appointments including speech and language therapy and the community paediatric clinic.

2.6 We heard that arrangements around multi-agency risk assessment conferences (MARAC) were working well and health practitioners received notifications of domestic violence incidents attended by police where children were present. However, there is no local programme for work with perpetrators of domestic violence across the area, which means that opportunities for preventative work are missed, [*recommendation 2.5*]

2.7 The Maidstone & Tunbridge Wells Trust has identified domestic violence champions who take an operational lead and provide advice and guidance to staff. The trust has good engagement with MARAC, with the named nurse attending regularly. Missing children and families are routinely discussed and children newly identified as being at risk from domestic violence are flagged on the Trust's IT system following each meeting, which is good practice.

Case Example: *A pregnant woman, "W", attended the emergency department at Pembury. Staff quickly identified safeguarding concerns through a detailed risk assessment; including that W was a victim of domestic violence.*

The ante-natal manager rigorously followed up the safeguarding concerns, taking prompt and appropriate action to protect the unborn child.

2.8 Pregnant women using services at Darent Valley hospital are routinely offered the chance to be seen alone at an early stage in their pregnancy. This enables midwives to make enquiries about sensitive issues such as domestic violence that the mother may otherwise feel unable to disclose. In Medway maritime Hospital, mothers who disclose domestic violence have their file marked with a recognised alert.

Case Example: *Following recent training on domestic violence, the use of a covert system to alert staff to concerns has been implemented at Darent Valley hospital. A pregnant woman, "G", used this at a routine appointment and staff were able to arrange time for her to be seen alone. "G" disclosed domestic violence and concerns for the safety of her older child.*

All staff involved in this case employed a persistent and pragmatic approach to ensuring this mother and child's safety. They quickly raised a detailed and well-articulated safeguarding and police referral, which resulted in a detailed plan of action that led to the mother and both children being protected.

2.9 These strong arrangements are not routine practice across all areas however and this is a particular area for development at the Medway Maritime hospital which provides maternity services for Swale residents. Awareness and practice in addressing issues relating to domestic violence across health visitors was extremely variable. We heard of instances where the issue wasn't routinely addressed by health visitors, which could leave mothers and children at risk. This was raised to the attention of safeguarding leads during the review for immediate action [*recommendation 3.5*]. Safeguarding leads in the Kent Community Health Trust recognised that there is work to be done to promote good practice in this area, and we were pleased to hear that seven new health visitors have been appointed to lead on domestic violence issues. This will help underpin a drive to improve practice across the service.

2.10 It was reported that the Kent Domestic Abuse Consortium (KDAC) has funding available for a pilot of an "Identification and Referral to Improve Safety" (IRIS) project in Kent. The consortium would fund practitioners to train and work alongside GP practices to support health staff to undertake safe enquiries, and support any patients living with abuse and their children. However, this welcome initiative had not yet been implemented at the time of this review.

3. Child protection

3.1 All emergency departments that we visited had a system for risk assessment of children and young people who attend. From January 2014 Maidstone & Tunbridge Wells Trust emergency departments had introduced separate and distinct paediatric emergency treatment cards, incorporating a safeguarding risk assessment. This is a positive development. The safeguarding risk assessment is good, encompassing the total number of attendances, who is accompanying the child, adult and child interaction, any delay in presentation and any discrepancy between injury and account given. This provides practitioners with effective triggers to facilitate good safeguarding risk assessment. We saw some examples of good safeguarding risk assessment there, with prompt action being taken by practitioners to seek further information or refer concerns. Practice is patchy however as we also saw a few cases where the safeguarding risk assessment had not been completed and obvious safeguarding issues had been missed. This indicates that quality assurance of risk assessment is not sufficiently embedded to ensure a consistent standard of practice, [*recommendation 1.3*]. we saw the following example of good risk assessment and practice :

Case Example: At Maidstone hospital, a 17 month old baby was brought in by her mother, and was seen by a junior doctor who had only started in the department the previous day. The doctor was diligent in observing the interaction between the parent and the child, and became concerned that this was a non-accidental injury. The doctor sought advice from more experienced staff and an x-ray provided evidence that the injury was not consistent with the explanation given by the mother. The doctor consulted with paediatric staff and alerted children's social care services prior to transfer for treatment.

3.2 Reception staff at Pembury hospital emergency department demonstrated a good understanding of their roles and responsibilities in safeguarding children. A receptionist we spoke to was able to cite examples when reception staff had identified concerns at the point of registration and had promptly and appropriately reported these to the triage nurse who instigated further enquiries. The MTW trust's electronic record for every adult or child attending the emergency department requires that a record is made of whether any safeguarding concerns have been identified. This has been developed as a result of a past serious case review and is a positive inclusion. However on a few cases reviewed, the electronic record showed no safeguarding concerns had been identified although this was contradictory to the evidence recorded by the clinician on the treatment card. This suggests a lack of understanding of either how the electronic record should be completed, or what constituted a safeguarding concern, [*recommendation 1.4*]

3.3 The Named Nurse for safeguarding children in Medway Maritime hospital emergency department has introduced a paediatric summary form which should be completed for all assessments of children and young people up to the age of 18, locally known as the "yellow" paperwork. This provides a robust and consistent approach to information sharing and planning a co-ordinated approach in providing care and support to vulnerable children and families. The demographics of children and young people attending the emergency department are recorded by the practitioner working in navigation and should be checked by the treating clinician. The form prompts nurses and clinicians to assess injuries against the NICE clinical guidelines for non-accidental injury and to check demographics obtained at booking in. This culminates in a discharge plan which makes sure that all practitioners involved in the child's care have been included and notified of what action has been agreed. Whilst we saw good practice in records being completed by practitioners working in the paediatric area, the form is not being used consistently by clinicians who are assessing and treating children and young people in the adult areas when the paediatric emergency department is closed. In the majority of these cases where the assessment was missing we also saw poor recording of an attending child's pain score and variable recording in parental consent, [*recommendation 8.1*]

3.4 Positively, staff at MT&W emergency departments are routinely involved in child protection strategy discussions and decision making. This is achieved in a variety of ways including strategy meetings taking place in the hospital or via teleconferencing, which promotes more effective multi-agency working and continuity of care in child protection.

3.5 All adult patients attending for emergency treatment at Pembury emergency department are routinely asked when registering whether they care for any children and we found examples of very good practice in responding to concerns about the welfare of the children of adults who presented there.

Case Example: *A woman attended the emergency department at Pembury hospital. A good risk assessment by staff identified safeguarding concerns as the mother had attempted suicide, and was the carer of a school-age child. The mother left the emergency department before treatment. Staff called her mobile number several times but got no response so called police for a welfare check. Police undertook a visit but did not see the child to ascertain his wellbeing. The emergency department doctor was dogged in continuing to follow this up with police, to ensure that the child was actually seen to ensure that he was safe. The doctor referred to children's social care for follow up, and the safeguarding children nurse liaised with the school nurse to follow up with contact with the young person*

3.6 While we found examples of good practice, awareness of hidden harm and child protection in emergency departments when adults present for treatment needs to be more firmly embedded across all the sites that we visited. The identification and recording of children in households of adults who attend the emergency department following incidences of domestic violence, self-harm, mental illness or substance misuse were underdeveloped. While policies were in place at Maidstone hospital that all clinical staff are expected to obtain a social history from adults and determine if children live in the household, there are no specific tools for doing this, which creates a potential risk that concerns and safeguarding issues could be overlooked. In all cases we reviewed at Medway Maritime hospital, the assessments were focused on the clinical presentation of the adult and did not explore or record any information on any children in the family or other social concern. This is of significant concern as most serious case reviews highlight the existence of adult risk based behaviours as contributory factors in child deaths, [recommendation 7.1]

3.7 Deficits in the physical design and capacity of the emergency department at Medway Maritime hospital including lack of supervision of the children's waiting area are well known to commissioners and providers, and have been highlighted in other recent inspections by CQC. An action plan is in place to undertake refurbishment with a new paediatric area created by 2015. We remain concerned that insufficient action is being taken to mitigate the risks to children and young people attending the service that arise while the current arrangements remain in place. We were concerned to hear of excessive waits, some of which meant that young people were waiting in adult areas for over two hours at evening times which are busier and means that young people are in areas with many adults attending, including some who may be intoxicated [recommendations 8.2 & 8.3]. We also heard of examples where people who have brought their child into the department but who leave before they have been seen due to the long waiting times are not properly followed up, [recommendation 8.4]

3.8 At Pembury hospital, the dedicated children's waiting area in the emergency department cannot be effectively observed by staff which increases the risks to children's health and wellbeing [recommendation 1.5]. The hospital does not have a missing child policy in place [recommendation 1.6]. We concur with the findings of a recent CQC inspection that arrangements for the emergency treatment of children within the body of the adult emergency department increases risks to children, and recommendations have been made for the Trust to address this. We also found that the current out of hours arrangements for paediatric emergency treatment can lead to significant delay in accessing paediatric expertise. If paediatricians cannot come to the ED, children have to be accompanied to the paediatric ward which is at a considerable distance, thus reducing ED nursing capacity [recommendation 1.7]. We are pleased to hear that a CQUIN¹ was put in place during the week of this review, with additional funding identified to ensure that these issues are addressed as a matter of priority.

3.9 All Minor Injury Units have excellent risk assessment and safeguarding forms that include identification of any vulnerable adults as well as children. We saw good examples of good identification of concerns, prompt response to vulnerabilities identified, and clearly documented referrals to children's social care. The use of a risk assessment for sexual activity for under 16 year olds requesting emergency contraception is a positive innovation that helps raise awareness of potential sexual exploitation.

Case Example: *a fifteen year old female attended the minor injury unit at Sevenoaks accompanied by her family. She had been harming herself and had told people that she was going to commit suicide. The emergency nurse practitioner did a detailed risk assessment and promptly contacted the psychiatric clinician at the hospital. This ensured that the young person had a mental health assessment and physical treatment that same evening. The ENP was diligent in assuring herself that the child had been taken to see the paediatric registrar, and a referral was made to the central referral unit.*

The young person was effectively protected and had a prompt response by health professionals in different services.

3.10 Kent Community Health Trust have a system of link safeguarding workers who provide advice, support and practice oversight across the MIUs relating to screening and risk assessment. However, we found inconsistency in arrangements for the oversight of safeguarding referrals. In one area all notifications of attendance of young people at MIUs are sent to a central administration team to log on a computer rather than through safeguarding link workers which means that there is not a robust review of attendances and practice in risk assessment and detection of early help needs [recommendation 3.6].

¹ Improvement target with financial incentives for delivery

3.11 We saw evidence of improving engagement of GPs in safeguarding processes. The GP practices that we visited had safeguarding and vulnerabilities flagging systems on their electronic records. GPs have been included in recent training programmes around safeguarding, and NHS England Kent & Medway has recently launched an extensive safeguarding training programme targeting GPs. The GPs with whom we met have safeguarding contact sheets and are aware of how to make a safeguarding referral.

Case Example: *a highly vulnerable care leaver with learning disabilities had been placed in a mother and baby foster placement following the birth of her child. The baby was on a child protection plan. When the young person visited her GP, she brought the baby into the room alone. The GP identified from the child protection plan that she should not be in charge of the baby unsupervised and promptly rang the health visitor to ask her to follow up urgently, ensuring that there was no risk to the baby. The health visitor did this and established that the foster carer had come to surgery with the mother and waited outside while the mother had her appointment. There had been no risks to the baby.*

The health visitor informed children's social care of the incident the following day at a scheduled child protection meeting.

3.12 The GPs that we met were committed to attending child protection conferences whenever they could and showed us case examples where they had attended. One GP attended the local MARAC whenever possible. One practice ensures that all registrars placed with them attend child protection conferences as part of their training which is good practice. We also found one example of very good identification and response to child protection concerns by a GP. However, improvements are being made from a low base and are not yet embedded across all practices. Health professionals across services told us that GP attendance and participation in child protection processes is rare and submission of GP reports to conferences is not routine. Alternative means of securing GP participation e.g. tele-conferencing have not been explored, [recommendation 9.1]

3.13 There is a good system across the Maidstone and Tunbridge Wells Trust for safeguarding alerts to be shared across maternity services, and if appropriate the hospital security team. Photographs of adults presenting risks can be included which helps enhance safety measures.

3.14 Midwives prioritise attendance at pre-birth meetings and child protection conferences and attendance rates are high. Where the case practitioner is unable to attend, the teams are diligent in ensuring another team member attends. Less experienced practitioners are well supported to participate effectively in child protection processes by supervisory staff and the safeguarding leads.

3.15 Positively, midwives can refer vulnerable women who are pregnant to children's social care at an early stage. In cases where there are identified child protection issues and midwives identify that a woman is likely to deliver early, they report that their professional opinion is respected and acted upon. However midwives experience variation in the timeliness of response and there is no written agreement or policy around pre-birth planning. The quality of pre-birth planning that we saw is extremely variable and although midwives told us that agencies usually work well together to respond to pre-birth concerns, there are occasions where cases are raised with the named midwife or named nurse for escalation, [recommendation 2.2]. We saw some examples where poor recording undermined child protection practice for example, in updating child protection plans once a baby has been born, or recording the date of the next conference on the baby's records. [recommendation 4.1]

3.16 Where the mother has mental health problems, practitioners reported that the mother and infant mental health service (MIMHS) routinely attend child protection conferences when they are involved which supports joint assessment and care planning in peri-natal care.

3.17 Arrangements for parenting capacity assessments are unclear and there are challenges created by lack of local mother and baby facilities which undermines optimal care planning and treatment for some mothers, [recommendation 2.2 & 2.3]. However, a change in policy at Darent Valley hospital that allows fathers to stay on the maternity ward without time restriction is felt to be helpful in allowing parental interaction to be observed by staff.

3.18 Midwives and health visitors undertake joint visits as appropriate, which supports continuity of care. Health visitors prioritise young people on child protection plans for enhanced services.

3.19 We found good practice within CASH with all young people under 18 years having a safeguarding assessment to explore risk and vulnerability; any young person under 13 who attends for CASH is advised that a referral is made to children's social care. Records reviewed showed that there are clear pathways for assessing risk, which are understood by staff and are being implemented effectively. Where any risks are identified staff engage with the young person to ensure needs are managed in a responsive and supportive way. Outreach workers are part of the wider multi-agency locality groups, and work closely with other professionals to support vulnerable young people. In all cases we reviewed the safeguarding assessments had been completed, along with a confidentiality statement and preferred method of contact. This ensures that CASH staff communicate with young people in a way that they have agreed and only share information with their consent where this is safe and practical, which is good practice.

3.20 A flagging system is in place across CASH services to identify children looked after or who are vulnerable. Staff reported improved links with the learning disability teams and the service now has its own link nurses, although this is in its infancy. They told us that staff from learning disability services are more confident when referring patients to the service and making better use of the outreach team. The service is represented effectively in local arrangements to identify and respond to concerns around sexual exploitation and trafficking, and staff spoken to were able to confidently explain how they would escalate concerns.

3.21 We heard some concerns from health professionals that there are insufficiently robust arrangements for children and young people requiring services from the sexual assault referral centre (SARC) following the closure of the service that was provided at Darent Valley hospital. There is now a service at Maidstone hospital hosted by KMPT, but it was reported that this is for adults only. In addition, it was reported that there are insufficient paediatric forensic examiners to ensure that examinations are undertaken in line with national guidance, and that accessing a service out of hours is a particular challenge, [*recommendation 9.3*]

3.22 Overall, we have seen numerous examples of committed and diligent practitioners across services working hard to protect children across the range of health services that we visited. Staff were clear about thresholds for referral to Kent's multi-agency safeguarding hub, known as the central referral unit (CRU), and we saw a number of examples where having a health component at CRU expedited a more timely response through improving information gathering and decision making. A range of professionals and senior management confirmed their experience of a positive response from CRU, including notification of action being taken. In addition, training has been delivered by named nurses and a worker from CRU using anonymised examples of actual referrals to promote awareness of thresholds. Positively, CRU are undertaking an audit of referrals to the team, particularly outcomes for cases that were not accepted and this will help identify if appropriate referrals are being made or if further work is needed to help people understand thresholds.

4. Looked after children

4.1 We found extreme variation in the arrangements for undertaking initial health assessments (IHAs) across the three areas that we reviewed. This had a significant impact on their quality and timeliness. Legacy arrangements from the Primary Care Trusts, unclear commissioning and a lack of specific job descriptions or service level agreements have resulted in a system that is not robust and leads to unacceptable inequity of service to some very vulnerable young people. There are clear arrangements for IHAs to be undertaken by the designated doctors or appropriately experienced members of their team in the West Kent and Dartford , Gravesham and Swanley areas. However we found that there are insufficiently robust arrangements for young people in the Swale area, in particular for young people over twelve years of age who are not on a pathway for adoption. The lack of formal contractual arrangements for this group means that their IHAs are arranged on a case by case basis by the administrative co-ordinator for the looked after children's health team. There is no arrangement for the quality assurance of these or system for reporting on performance to the CCG. We found evidence that these arrangements are leaving children looked after in the Swale area at an unacceptable risk due to the lack of consistency in quality or timeliness of access to an assessment, [*recommendation 10.1*]

4.2 Some examples of IHAs and associated plans relating to Swale young people are extremely poor, lacking depth and exploration of emotional health and well-being. Some are significantly overdue – for example, one young person in a mother and baby foster placement did not have an assessment for over six months, and in another there was an eight month gap between the IHA and the production of the associated health action plan. There is no consistent gathering of maternal and paternal health histories and the health plans do not contain SMART objectives. This poor practice has a negative impact on being able to accurately identify existing and potential health needs and plan for the future for these very vulnerable children and young people. The inadequacy of these was only highlighted by the excellent examples of assessments and on-going medical care that young people in other areas receive. Some of the IHAs undertaken in West Kent are to be commended for innovations including a section on 'generic future risks', which outlines issues relevant to the young person, the consequences for their health and well-being, and implications for any carers to be aware of. However, despite the quality of these assessments, work is needed across the board to improve the standard of health action plans which do not always reflect the health needs described in the assessment, are not clear or measurable, or are not presented in a format that could be readily used by colleagues following up the health of the young person concerned, [*recommendation 10.3*]

4.3 We also found that there is no clear framework for the quality assurance of IHAs undertaken for unaccompanied asylum seeking children. Information in the clinical records and the inspectors discussion with a GP undertaking IHAs for this vulnerable group clearly demonstrates that the GP conducts the assessment well, making efforts to draw out the voice of the child and trying to ascertain sense of the individuality and experiences of the young person as an asylum seeker. However, this excellent practice is not reflected in the completed assessment formats or associated health action plans, which could mean that critical health information could be lost. We heard that there had been no training on the completion of IHAs and the lack of quality assurance means that poor practice would not be identified or addressed, leaving this vulnerable group without adequate health plans as they move through services, [*recommendation 10.1*].

4.4 Positively, the interpreters used by the reception centre for unaccompanied asylum seeking children are well trained and have a good understanding of the health and social care processes as they relate to this group. This helps them play an important role as an integral but independent part of the team of professionals providing support, which includes accompanying them to health appointments and assessments.

4.5 The CIC (children in care) service comprises three specialist nurses. They undertake all review health assessments (RHAs) of young people looked after by Kent, including those children placed out of county, in addition to undertaking reviews for children placed in Kent from other local authorities. With a current vacancy in the team capacity is extremely stretched. Undertaking RHAs is prioritised, but there have been particular challenges for the team around monitoring the health of young people in out of area placements - this issue has been escalated and an action plan developed to address it. It was also acknowledged that there have been problems getting young people over sixteen years old to engage and numbers having a RHA have been low. We heard that there are plans to recruit a nurse practitioner to work with the paediatrician in progressing these, which is a timely development. The structure of the team has been reviewed although the final configuration has yet to be determined, and there is some concern due to the uncertainty of future arrangements and the capacity of the service to meet demands, [*recommendation 10.4*]

4.6 Specialist nurses have been co-located with the local 'virtual school' education team, and staff reported that they liked being part of a multi-agency team with health working alongside education. However, CIC nurses are now unable to directly access community child health records, which previously had supported them in the ongoing monitoring and review of children and young people in their care. This undermines positive outcomes for looked after children's health. In addition, we found that the CIC nurses report that they are not notified when young people entered care, when their IHAs were due or undertaken, and did not receive copies of the subsequent reports. This means that the team are unaware of which children have come into care until their scheduled review which could be twelve months away. This is an issue of significant concern. We found one example where this had contributed to lack of co-ordination around a very vulnerable young person and missed opportunities to monitor their health and well-being due to lack of timely information sharing. We have referred this case back for follow up, [recommendation 10.4]

4.7 Examples of review health assessments that we saw were generally of a good quality and we saw some of a very high standard. They generally contained evidence of sensitive discussion around a child or young person's emotional health and wellbeing. Risk taking behaviours were also routinely reviewed and in one case details were included in the assessment but were not included in the health plan at the request of the young person. This demonstrates the commitment of the CIC health nurses to maintaining the confidentiality of the young person whilst making appropriate arrangements and referrals to keep the young person safe. However, we did not see any reviews where ongoing substance misuse was disclosed or the local assessment form used. Referrals to the local Kent youth substance misuse service are low, which could mean that the RHAs are not identifying potential or existing substance misuse, [recommendation 10.1]

4.8 The review health assessments considered all available information from foster carers, the child's GP, the current SDQ where available and details of any attendances at emergency departments. However, the team are not always informed when young people have attended an emergency department, and there are no clear arrangements for ensuring that they are kept up to date with any changes in the young person's physical and emotional well-being, or any child protection concerns. This means that they may not have a full history when reviews are carried out and children and young people may subsequently have their health needs missed or be placed at risk, [recommendation 10.1]

4.9 The reviews that we saw made reference to previous actions outlined in health plans and the progress made. Examples of newly developed health plans that we saw correctly identified health needs but were not SMART, which may mean that action on health issues may drift between assessments, [recommendation 10.3]

Case Example: A fifteen year old female came into care two years ago. The initial health assessment carried out then contained some maternal and paternal health history. Over the past two years her foster carers, GP and other professionals involved with her health care had been invited to contribute to the annual health reviews. The reviews and subsequent health plans clearly document an improvement in the young person's emotional health and wellbeing whilst in care.

Although the young person had not directly completed a SDQ, she reported to the CIC nurse at her last review that she was much happier and felt more content since becoming looked after and talked positively about her career aspirations.

4.10 There is a quality assurance process in place for Kent children placed out of area. All reviews forms that are returned should be scrutinised although we did not see examples of this and we heard that there are challenges in maintaining this due to current capacity issues. There was also concern at the lack of continuity in health review assessments for children and young people who transfer between teams across Kent. This could lead to significant drift in the health needs of a young person being met or not met at all, [*recommendation 10.1*]

4.11 There are no arrangements in place to provide young people leaving care with a health summary to help them to understand their individual and family health history. This could undermine future assessments of their health needs. This lack of health history is something that young people we spoke with felt strongly about, and remains an outstanding action from previous inspection recommendations, [*recommendation 10.5*]

4.12 Children and young people have been consulted about their preferences for review health assessments, and indicated a preference for these to take place as a home visit rather than at a clinic. CIC nurses report that this is prioritised, although young people in care with whom we spoke did not always feel they had this choice [*recommendation 10.2*]. The CIC nurses are involved in developing a new "CIC pack" including information for young people on what to expect from health. They have participated in the looked-after children activity days, running sessions on healthy eating but they have not yet met with the children in care council to discuss how health assessments and reviews could be improved or what health support care leavers should expect. We heard variable feedback on the experiences of young people regarding health input. Overall it has not been identified as helpful or effective e.g. reviews are overly brief, or not covering all health areas such as sexual health or immunisations for older children – some of whom only found out they needed immunisations later through their GP. One young person had very poor experience of a CIC nurse repeating a private conversation with her foster carer which made her feel undermined by the nurse, [*recommendation 10.7*].

4.13 Young men using the service for unaccompanied asylum seekers in Ashford spoke positively about the support and service that they had received there in terms of their health. This is helped by having close links with a nearby GP service and we saw some examples of timely and effective response to medical needs. However, it was unclear why two young people with a medical problem had not been seen in person after 9 days, with only telephone advice sought. Many unaccompanied asylum seeking children have dental health issues which are routinely identified at their initial health assessments, although it was not clear whether these are routinely met during the young person's time at the centre. The main concern of the young people that we spoke to concerned the lack of activity including physical activity which undermines healthy lifestyles.

4.14 SDQs are sent out to foster carers. Young people are not routinely asked to complete their own SDQ and this is a missed opportunity for those young people to contribute to the assessment and planning of their emotional health and wellbeing, [*recommendation 10.8*]. The records we reviewed and the discussions with staff indicate that CiC staff are identifying any emotional and mental health needs as part of the health review processes. However, the specialist nurses are not able to directly refer to the specialist CAMHS service for children looked after, and there is no system for routine liaison or information sharing between the teams. This is a missed opportunity to promote speedy access to services and to strengthen joint working across health teams to promote positive health outcomes for looked after children, who are more liable to have difficulties in their emotional and mental wellbeing [*recommendation 10.8*]. We saw examples of high levels of support given to foster carers around bed wetting and behaviour management strategies, and one foster carer told us that they had had good information and support around managing health issues relating to the young person that they cared for.

4.15 Young people who are looked after are able to access specialised individual support from outreach CASH services which is highly valued. This was felt to be a strength of the service and the CiC nurses told us that young people spoke highly of the support they received. There are specific clinics held to support unaccompanied asylum seeking children, which are supported by interpreters where needed.

4.16 We were concerned to learn of incidents where children looked after had not attended clinical appointments in local hospitals, and they had been discharged with foster carers asked to return to the GPs for a re-referral. This can lead to unnecessary delay in these vulnerable children receiving healthcare, [*recommendation 11.1*]

4.17 We were told that school nurses believe that they need to hand the care of children and young people to the specialist team when they become looked after. We are unclear as to how this process works and fits in with the role of the looked after children's nurses, and we heard of one case where a young person's health needs were not addressed for twelve months, due to lack of appropriate handover and delineation of responsibility, which had a negative impact on their well-being, [*recommendation 10.6*]

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 All three CCGs report that they have an accountable officer and executive lead for safeguarding in place. The responsibility for safeguarding children and vulnerable adults sits within the portfolio of the Chief Nurses, who attend the Kent Safeguarding Children Board (KSCB) executive group. The KSCB covers the seven CCGs across Kent, and there is a separate LSCB for the Medway area. The challenges in providing leadership across a large geographical area with multiple providers are acknowledged and understood by all partners involved in the KSCB. This has become more complex since the changes in the local health commissioning arrangements when the two Primary Care Trusts (PCTs) in Kent were replaced by the CCGs. There is evidence of increasing engagement of health partners in the KSCB now that representation from the CCGs has been more firmly established. The range of partners that we spoke to during this review acknowledged that the KSCB was benefiting from positive working relationships and commitment across agencies, but it was recognised that the leadership role of the board was still developing. Positively, over the last year the KSCB had initiated a 'Look Back' exercise to encourage providers to relate learning from serious case reviews to their own organisations, and jointly hosted an "immersive learning event" for the CCG safeguarding team to test the commissioners' knowledge and readiness to respond to a complex safeguarding incident. It was felt that this valued work could be built upon to drive the effectiveness of the board. This was described as a key priority by the newly appointed Chair of the KSCB, who was initiating individual discussions with all key stakeholders to clarify their aims and contribution to the board which will be used to develop jointly agreed priorities. This is good practice that will support the development of a clear vision across partners and stakeholders.

5.1.2 There have been some recent changes to the structures supporting the KSCB, including the disbanding of the previously established local LSCB groups. We heard from health professionals who felt that they had lost a valued opportunity for discussion of safeguarding at a local level, and some areas have set up local health focus groups to address this. A Health Service Group (HSG) has been established for some years, and has recently been recognised as a formal sub-group of the KSCB. The HSG is currently chaired by NHS England, and attended by Chief Nurses and all accountable provider safeguarding leads. This is viewed as a valuable quarterly forum to promote a focus on health issues and provide clearer leadership to drive improved practice across the health economy.

5.1.3 Following the change in commissioning arrangements from PCTs to CCGs, arrangements for the provision of the designated safeguarding and looked after children's service across Kent have been under review, and arrangements were made for the team to be 'hosted' by Medway CCG. A detailed review of the 'hosting' arrangement was undertaken in September 2013, which included a broad assessment of needs and the effectiveness of the service. A report with recommendations was delivered to the Safeguarding Partnership Board in October 2013. This report recommended the continuation of the 'hosted' model, with action to be taken to strengthen the model and ensure that it is effective in its strategic and governance role. The team has recently been strengthened by the recruitment of additional designated nurses for safeguarding, although recruitment to an additional post for a designated nurse for looked after children is proving challenging. Work is being done to clarify and formalise the arrangements for the designated doctor for safeguarding role, as there has historically been no clear commissioning or job description in West Kent. This has been covered by community paediatricians without any service level agreement until now, and while the need for firmer arrangements with more capacity has been identified, the final configuration of service has yet to be agreed. The progress made in these arrangements to date is generally viewed positively by providers and commissioners and clearly creates capacity to address some long-standing gaps in strategic oversight, performance management and driving improvement. [*recommendation 10.4*]

5.1.4 However, there is a lack of consensus across all the relevant stakeholders as to the benefits or otherwise of the current model, and the clinical commissioning groups were undertaking further work to scope this and identify options for future service configuration. There is some concern across the economy about the future of the arrangements and the impact of a possible fragmentation of the service. Providers and other stakeholders have expressed concerns about the challenges that this would create, and would regret the loss of a "single point of access" that could bring benefits from having a whole systems approach across Kent and Medway. We heard that the hosting arrangements are seen as having the capacity to provide greater flexibility and responsiveness than would be the case if there were more locally devolved arrangements. Commissioners and partners across the CCGs that we visited are working together to identify an optimal solution although the final outcome is as yet unclear. NHS England Kent and Medway has written to all CCG Accountable Officers and Chief Nurses in Kent, requesting a submission by 30 April 2014 of their safeguarding plans for 2014/15. NHS England Kent and Medway are convening a panel in early May to review the CCG safeguarding plans.

5.1.5 There are two designated doctors for looked after children in the area. However, the commissioning and service delivery arrangements for these posts are unclear and have resulted in a system that is not robust and leads to unacceptable inequity of service to some very vulnerable young people. As noted above, there are inadequate arrangements to ensure that young people looked after in the Swale area benefit from adequate and timely initial health assessments. The doctors' roles are not underpinned by clear job descriptions and while having a clear strategic element, are not in line with the role of the designated doctor as set out in NICE guidance or "*Promoting the Health of Looked after Children*". There has been inadequate governance, and a lack of management oversight or prioritisation of the situation for some time. While individual practitioners have been aware of and had concerns about the gaps in the service, this has not led to action to address the matter, and the CCGs are at risk of failing in their corporate parenting role should this situation continue, [*recommendation 10.4*]

5.1.6 GPs that we met reported good contact with the NHS England area team, and felt that they and the CCGs are demonstrating increasing safeguarding leadership and drive for improvement. The single Named GP who is in post delivers some training and provides GPs with safeguarding advice and guidance. However the remaining named GP post has been vacant for a significant period of time, and there remains some uncertainty as to how this will be filled. NHS England is giving consideration to developing a non-medical model although this is yet to be decided. GPs we spoke to were unaware of any proposed alternative model and felt some concern about the leadership and support for them as a group. We heard comments including that "*safeguarding is happening without us*"; feeling a lack of cohesiveness, and concerns about not being sufficiently equipped to safeguard children effectively. [*recommendation 9.2*]. There is no GP safeguarding forum or federation of GP safeguarding forums in Kent, limiting GPs opportunity to meet peers regularly to develop their understanding and knowledge, engage with partner agency experts and learn from shared case examples. There was evidence that such an opportunity would be welcomed, and NHS England reported that a local forum for Kent is being developed with a planned date for the first meeting in June 2014.

5.1.7 Across all partners that we spoke to during this review, there was an acknowledgement that commissioning of services for children and young people had been “fragmented” in the past, and that this was a priority area for development across partners. The lack of robust joint strategic planning and commissioning has been highlighted by recent concerns about the adequacy of CAMH services in Kent. In 2013, NHS England Kent and Medway together with the Surrey and Sussex Area Team convened a partnership workshop to fully understand and address the full provision of services to support the emotional and mental well-being of young people across the area. West Kent CCG, the lead commissioner for mental health services across Kent identified actions to address the risks identified, and the NHS England Strategic Clinical Network established a steering group to support this. West Kent CCG have made clear progress in mapping provision, driving service improvement, and also identifying gaps and challenges across the service. Within a relatively short period of time, work has been done to effectively develop the foundations for more effective partnership working to address those gaps and begin to develop a joint commissioning strategic approach. A briefing paper was presented to the Health and Overview Scrutiny Committee in January 2014, which set out actions that had been taken to address performance issues across the service and the resulting performance improvements. However, this is still at early stages. The commissioners have a clear grasp of the risks within current arrangements and need to ensure that there is a strong infrastructure supported by a jointly agreed vision and integrated strategy across partners, without which continuing progress could be undermined.

5.1.8 Work on the integration of commissioning has also been highlighted across partners in Kent, as the area has recently been awarded ‘pioneer’ status for integration. This national NHS England programme invites local areas to demonstrate the use of ambitious and innovative approaches to deliver person-centred, co-ordinated care and support. This will support a more comprehensive approach to joint strategic planning and commissioning across services for children and young people. There are plans to refresh the Kent joint strategic needs assessment and the health and well-being strategy, which is a timely development that will support positive outcomes for young people through a coherent approach to service development in Kent. In the interim, we heard some concerns from health practitioners that the current lack of a robust joint approach to service development could mean that potential negative implications for the health outcomes for young people would be overlooked, in particular relating to the imminent retendering of contracts by partners. Practitioners are unaware of how to appropriately raise these concerns, and the issues were flagged by the inspection team during this review to health commissioning leads.

5.2 Governance

5.2.1 Quality assurance structures across the health economy are being strengthened relating to both the performance management of commissioned health services and in relation to the arrangements for safeguarding children and young people. A wide range of stakeholders reported that the KSCB was becoming a more effective driver for improvement and this is benefiting from the improved engagement of health representatives. The KSCB was developing a more robust performance management role, and stakeholders identified the creation of a quality surveillance sub-group as a key factor in strengthening the governance infrastructure, for example in the development of an agreed dataset to inform performance reporting dashboards.

5.2.2 The CCGs are able to demonstrate the impact of a more robust and effective performance management system across a health economy where this had been weak. There are clearer structures to hold providers accountable for their performance and there is evidence that this is driving improvements across services, although progress is uneven across different providers. Each CCG monitors safeguarding within the health provision that they commission through their quality performance meetings. The safeguarding team has commenced requesting safeguarding activity from health providers and these figures are reported in turn to the Chief Nurse with quarterly safeguarding data reporting. Providers are being assisted to develop their systems for reporting to the CCG on performance indicators including safeguarding, as previously the systems have not been in place to do so. Provider trusts have effective internal governance structures although it is widely acknowledged that there was previously little external challenge to performance. Performance reporting is improving and there is strong evidence that this is helping to drive up performance and improved practice particularly around safeguarding, although this is felt to be a '*work in progress*' as providers have variable infrastructure to be able to provide data.

5.2.3 Across the provider trusts that we visited, named safeguarding leads are in place with responsibilities that include oversight of the quality of practice in relation to safeguarding. Systems for quality assurance varied and a culture of performance management and audit is not fully embedded. Generally, good systems are in place to ensure that safeguarding leads are notified where concerns have been identified and this enables them to review and reflect on practice. However, there is insufficient oversight of a wider sample of practice that would ensure that all concerns are being appropriately identified and this is a missed opportunity to test the effectiveness of systems as well as to develop reflective learning. We also found examples across the range of health services including those for looked after children, where escalation processes have not been initiated. There has been insufficient managerial oversight in some cases where health professionals had concerns about responses to referrals, or where there was professional disagreement about the level of risk to children and young people. This could leave young people or families at risk, as well as undermining quality assurance or assessment of joint working arrangements, [*recommendation 12.1*]

5.3 Training and supervision

5.3.1 Across the four emergency departments that we visited, we found insufficient numbers of paediatrically trained staff to provide a service in line with national guidelines. This also had been highlighted in recent CQC inspection reports across all four hospital sites. While recruitment is underway at Medway, and a business plan is being developed to address the issue across Maidstone & Tunbridge Wells Trust, this has not yet secured the improvements intended which means that young people are not always accessing the specialist advice that they need, particularly out of hours, and this creates potential for risks to go undetected, [recommendation 13.1]

5.3.2 Over the last year, the CCGs have required provider trusts to report on compliance with national guidance relating to safeguarding training. Some have experienced challenges in providing comprehensive detail, although this is improving. GPs report a recent significant increase in safeguarding training being offered by CCG and NHs England. Generally, providers are reporting good compliance with training at Level 1 safeguarding, but with some gaps at Level 2, although there is considerably weaker performance in some providers. Reporting of performance in training at level 3 varied considerably, but we were not assured that the training as it is currently being provided at this level across the health economy is sufficient for the roles and responsibilities of the health practitioners undertaking it, or in line with national guidance. We also found evidence that some groups of staff may not be receiving the level of training that would be indicated by their role. This means that key services across health teams have been operating with insufficient numbers of staff who have had sufficient training in the identification, assessment and reporting of child protection issues which could leave young people at risk. [recommendation 11.2]. Maidstone & Tunbridge Wells Trust had identified training as an area for development. Darent Valley hospital trust has recruited a new level 3 trainer into the safeguarding children team, which is having a positive impact on staff training levels within the hospital.

5.3.3 The CIC nursing team have undertaken level 3 training provided by KSCB, which included child sexual exploitation, PREVENT (risk of radicalisation training), substance misuse and attachment issues. Practitioners report that this multi-agency training is excellent. We heard from midwives at Darent Valley that they have access to specialist training sessions on categories of abuse, domestic violence, and CAF that run yearly meaning that specific knowledge is updated annually in addition to statutory requirements. The impact of this training particularly relating to domestic violence is evident with more midwives raising concerns around domestic violence since the training was initiated. Specific safeguarding concerns are updated monthly at a multidisciplinary liaison meeting. Attendance at this is monitored and recorded, which is good practice.

5.3.4 There are variations in how well established supervision arrangements are across services. Midwives across different trusts have good access to supervision, However, supervision is not taking place in line with statutory guidance across the M&TW Trust emergency departments. KCHT has three named nurses who provide support to all community health staff. Health visitors and school nurses have an annual appraisal, quarterly clinical supervision and four monthly individual safeguarding supervision, which is good practice. However, safeguarding supervision is not taking place for MIU staff despite KCH Trust having a good policy on this. We have been told by the Trust manager that the issue of clinical and safeguarding supervision has been identified on the Trust's risk register and the Trust recognises the need to ensure that effective arrangements are in place. The named nurse at Sussex Partnership Trust has responsibility for delivering supervision in line with statutory requirements to CAMHs teams across Kent, in addition to overseeing safeguarding training and providing advice and practice development. The capacity to undertake this across a large service, which is facing significant development challenges including in its performance relating to safeguarding training, is stretched and there is a potential that the Trust will not secure and embed the improvements it intends in supporting staff in developing their safeguarding practice, [*recommendation 14.1*]

5.3.5 Positively, all CASH staff have accessed Level 3 safeguarding training and are supported in their practice by safeguarding supervision which is part of their clinical supervision. Quality assurance is through case review and audit and quarterly direct peer observation. Practitioners that we met were clear on safeguarding supervision and the process to discuss and highlight concerns.

Recommendations

1. Maidstone & Tunbridge Wells NHS trust should ensure that:

- 1.1 Documentation used by midwives to collate information to inform assessments includes requests for information about parenting capacity.
- 1.2 The hospital electronic flagging system includes identification of children looked after
- 1.3 quality assurance systems are in place to ensure consistent use and monitoring of safeguarding risk assessment forms in the emergency departments
- 1.4 electronic and paper records are consistent and accurately reflect risk assessments and safeguarding concerns
- 1.5 there are adequate arrangements for staff to be able to observe children and young people attending emergency departments to ensure their safety and well-being
- 1.6 that there are effective policies in place relating to missing children
- 1.7 children and young people have timely access to paediatric assessment and advice as appropriate

2. NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs and Kent & Medway Partnership NHS and Social Care Partnership Trust should ensure that:

- 2.1 There is an agreed multi-agency peri-natal mental health pathway that ensures that new and expectant mothers requiring support for mental health issues have prompt access to appropriate support at all levels of services.
- 2.2 There are clear arrangements for multi-agency pre-birth planning with clear responsibilities for undertaking parental capacity assessments
- 2.3 an analysis is undertaken of the provision of and access to mother and baby facilities with a plan developed to meet any unmet needs.
- 2.4 an analysis of unmet need identified through CAF is undertaken, with a plan developed to address any gaps in provision identified
- 2.5 an analysis of provision for services for perpetrators of domestic violence is undertaken, with a plan to address any gaps in services identified

3. Maidstone & Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust, and Kent Community Healthcare Trust, should ensure that:

- 3.1 Appropriate arrangements are in place for information sharing and care planning across midwifery and health visiting services and partner agencies to promote the health and well-being of children and families using services
- 3.2 health practitioners have a clear understanding of the common assessment framework
- 3.3 health practitioners have good access to e-CAF as required
- 3.4 practitioner referrals to children's social care clearly articulate the risks to the child or young person
- 3.5 robust quality assurance systems are in place to ensure that health practitioners are routinely making appropriate enquiries and taking action to ensure that people are safe relating to domestic violence, in line with national guidance
- 3.6 effective systems are in place for the monitoring and review of all safeguarding notifications across minor injury units

4. Medway NHS Foundation Trust and Kent Community Healthcare Trust should ensure that:

- 4.1 accurate and comprehensive record keeping is promoted across health visiting and school nursing teams, that supports specific, measurable and child-focused planning and care intervention

5. NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs, NHS England, and Sussex Partnership Foundation Trust together should ensure that:

- 5.1 children and young people attending emergency departments have timely access to CAMH services as appropriate
- 5.2 young people with mental health needs have access to appropriate facilities on admission to hospital
- 5.3 there are clear shared pathways of care for children and young people to access Tier 3 CAMH services, and that these arrangements are subject to effective clinical oversight and robust governance arrangements

6. Kent & Medway NHS and Social Care Partnership Trust to ensure that:

- 6.1 care plans reflect identified issues relating to children and young people as appropriate
- 6.2 there is an adequate system on the Trust's electronic record system for alerting staff to child protection issues

7. Maidstone & Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust should ensure that:

- 7.1 there are effective systems for the identification and referral of child well-being and protection issues across both the adult and paediatric emergency departments
- 7.2 clinicians and nursing staff in the paediatric and adult emergency departments have regular feedback from and discussion with paediatric liaison workers and safeguarding leads to support their work in safeguarding vulnerable adults and children

8. Medway NHS Foundation Trust should ensure that:

- 8.1 paediatric risk assessment forms are consistently used when young people attend the emergency department and are comprehensively completed
- 8.2 waiting times for children and young people in emergency departments are in line with NICE guidelines
- 8.3 children and young people attending the emergency department have access to safe and suitable waiting areas
- 8.4 staff comply with hospital policy on children leaving emergency departments

9. NHS England Kent and Medway together with NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs should ensure that:

- 9.1 there are effective communication links with across partners to ensure that GPs are appropriately engaged in child in need and child protection processes
- 9.2 there are adequate and effective arrangements in place relating to the role of the Named GP, in line with national guidance "*Working Together to Safeguarding Children*"
- 9.3 There are sufficient arrangements in place to provide a sexual assault response service to children and young people, including out of hours in line with national guidance

10. NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs together with Kent County Council and NHS provider services contributing to review and initial health assessments should ensure that:

- 10.1 children and young people who are looked after benefit from quality, timely and comprehensive initial and review health assessments by suitably qualified and experienced health professionals, subject to effective quality assurance and robust performance management and reporting arrangements, including young people placed out of area and unaccompanied asylum seeking children
- 10.2 review health assessments are held at the venue of the young person's choice
- 10.3 that health action plans are developed promptly following assessment, are SMART, setting out clear and measurable health objectives for the child and identifying those accountable for the delivery of outcomes within defined timescales.
- 10.4 to review the effectiveness of the arrangements regarding designated doctors and nurses, lead health professionals and specialist nurses for children looked after, and take action to ensure that there is adequate arrangements and sufficient capacity to undertake the requirements of the roles as set out in national guidance "*Promoting the health and Well-Being of looked after children*"
- 10.5 that care leavers are properly equipped with health histories, age appropriate information and contact details should they need to re-engage with the looked-after children's health team
- 10.6 there are clear accountabilities and effective arrangements for monitoring and responding the health of looked after children of school age, that are clearly understood by all relevant health professionals
- 10.7 arrangements are in place across services to promote privacy and protect the confidentiality of children and young people looked after
- 10.8 there are robust arrangements in place across services to promote comprehensive assessment of the emotional and mental well-being of children looked after, to share relevant information and to promote timely and effective access to support services

- 11. NHS West Kent, Swale, and Dartford, Gravesham and Swanley CCGs together with Maidstone & Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust, and Kent Community Healthcare Trust should ensure that:**
- 11.1 there is a jointly agreed policy relating to the non-attendance at medical appointments by children looked after that supports their continuing engagement with health services and ensures that there is no delays or barriers to accessing timely care
 - 11.2 staff have training commensurate with their roles and responsibilities in the protection of children and young people in line with national guidance
- 12. Maidstone & Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust, Kent Community Healthcare Trust, Kent & Medway NHS and Social Care Partnership Trust and Sussex Partnership Foundation Trust should ensure that:**
- 12.1 quality assurance systems are in place to monitor and review outcomes of referrals by health professionals including use of jointly agreed escalation processes to ensure that optimal outcomes for young people are secured
- 13. Maidstone & Tunbridge Wells NHS Trust and Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust should ensure that:**
- 13.1 that there are sufficient numbers of appropriately qualified and experienced paediatric staff available at emergency departments to promote the health and well-being of young people, in line with national standards
- 14. Maidstone & Tunbridge Wells NHS Trust, Kent Community Health Trust and Sussex Partnership Foundation Trust should ensure that:**
- 14.1 there are adequate arrangements in place to ensure that staff have access to regular safeguarding supervision in line with national guidance

Next steps

An action plan addressing the recommendations above is required from Kent 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.