Wednesday 11 November 2009

Ms Ann James  
Chief Executive  
NHS Cornwall and Isles of Scilly  
The Sedgemoor Centre  
Priory Road  
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Cornwall  
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Dear Ms James

Outcome of integrated inspection of safeguarding and looked after children’s services in Cornwall

I am writing about the recent joint inspection by Ofsted and the Care Quality Commission in Cornwall to provide you with more detailed feedback on the findings from the CQC’s component of the inspection. Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

As you will be aware, the team, led by Ofsted colleagues, provided feedback to your local Director of Children’s Services at the end of fieldwork and the report to the authority is now published.

This letter sets out more detail of the underlying evidence which relates to your organisation and the provider units from which you commission services. It incorporates relevant findings from the overall inspection report, but provides greater detail about what we found, in order that your organisation can consider and act upon the specific issues raised.
The Inspection Process

The inspection was conducted between 14 September 2009 and 25 September 2009 and was conducted under the framework for inspection of safeguarding and looked after children’s services published by Ofsted.

Ofsted’s inspection principle takes account of the extent service providers have sought and acted on the views of children, young people, families and carers when reviewing and improving services and outcomes generally. Inspectors will also consider the views of those users and stakeholders they speak to during on-site evidence gathering. Details of the organisations involved are listed at the end of this letter.

The findings contribute to Ofsted’s annual reviews of the performance of each local authority’s children’s services and its annual performance rating for each authority. The specific findings about health services’ performance may also be used by the Care Quality Commission as a part of the assessment of NHS provision, registered health providers and PCT performance in delivering commissioning outcomes.

CQC’s Involvement

As part of the overall inspection, CQC examined the effectiveness of the Commissioning PCT’s delivery of outcomes for children and young people. We looked at the PCT and its health providers as follows:

- the role of the board: how boards assure themselves in relation to safeguarding and the health of looked-after children
- whether staff have the right skills and experience to recognise concerns, share information and escalate problems where necessary

The points discussed during meetings with the PCT commissioning board members were further explored with staff and, where possible local children across the Primary Care Trust, its providers, GPs, and community health teams.

Joint Area Summary

The integrated inspection focused upon health and social care services in relation to implementing child safeguarding procedures and delivering appropriate outcomes for ‘looked after’ children. It looked at outcomes for children and young people and practices to improve children’s life experience. The joint inspection report was published within 20 days of completion of the inspection.

From the aggregated findings from the inspection, it was concluded that the overall effectiveness of the safeguarding services in Cornwall was Inadequate and capacity for improvement was Inadequate.
Overall effectiveness of services for looked after children and young people in Cornwall was judged to be \textit{Inadequate}. The council and its partners were also judged to have \textit{Inadequate} capacity for improvement.

\textbf{Inspection Findings for Health Partners}

The following sections provide details of CQC’s findings which contributed to the overall inspection report. These are separated into two sections: safeguarding and looked after children. Where possible, evidence is attributed to a specific organisation.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

\textbf{Key findings – Safeguarding and health}

\begin{quote}
\textit{Extract from inspection report of safeguarding and looked after children services – Ofsted October 2009}

The CAMHS is still not fully established and there remains a shortage of health visitors, school nurses and social workers. Social workers have high case loads with some children in need cases being counted as one case irrespective of the number of children in the family. A lack of capacity within the health visiting and school nursing service means they are unable to engage fully in health education and health prevention work with families. Similarly, a lack of capacity within the substance misuse service results in it being unable to deliver an adequate level of preventative work. Although commissioning arrangements are starting to show signs of improvement they remain under developed. Joint commissioning arrangements have not commenced.

The quality and consistency of substance misuse prevention work are variable. Resource packs are provided to schools together with a training package but the effectiveness has not been assessed. YZUP, the substance misuse service for young people, receives inadequate support from partners. Insufficient capacity means preventative work cannot be addressed as the focus of their work is with those who are in treatment programmes. Inadequate transition processes between children and adult substance misuse services result in a significant number of young adults over the age of 18 remaining in the YZUP service. YZUP experience difficulties in getting social care to accept referrals of young people with chaotic life styles and substance misuse difficulties and assess that 3\% of those with whom they are working would benefit from assistance through social care. This results in YZUP providing support to
\end{quote}
an individual young person in all areas of support, housing, benefits and transport. In September 2009 NHS Cornwall and Isles of Scilly agreed to commission a drug and alcohol liaison nurse to be based within the accident and emergency department and recruitment processes have commenced. If a young person is admitted to hospital with self harm and is known to be a substance misuser, the young person is only referred to YZUP. This is inappropriate as there may be other underlying mental health needs that should be addressed.¹

Two projects supported by the family nurse partnership and youth service for young mothers under 19 years of age are positively received by those benefiting from the service. The projects support young mothers to continue with their education, child care, socialisation, sexual health advice and contraception. Quotes to inspectors include; ‘it’s great, the midwife saw me as soon as I knew I was pregnant and I see her every two weeks. She was with me while I was pregnant and will stay with me until the baby is two. She tells me all sorts of things from child care, to health, and involves the baby’s father’, and ‘I only saw the health visitor from the surgery once, I have had much better care and assistance from this youth centre, I can see the health visitor each week if I need to’.

Findings arising out of serious case reviews have identified the lack of professional support for young fathers. The partnership is seeking to address this issue and one youth centre has employed a male youth worker to work specifically with young fathers. A new fathers’ group has just been launched for both birth fathers and step-fathers.

Training plans across partner agencies are variable with the exception of single and joint agency child protection training levels 1-3. Good progress has been made within the health communities to ensure staff, including general practitioners, receive the appropriate level of safeguarding training. Within health there are now robust recording systems to track and monitor the uptake of child protection and safeguarding training.

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Emergency Care

Emergency care is provided by the Royal Cornwall Hospitals NHS Trust. As within other areas of health there has been good progress to ensure staff receive the appropriate level of safeguarding training.

¹ Erratum – preceding two sentences. All children who are admitted with self harm must be seen before discharge by CAMHS. There is a referral form which is also copied to the Safeguarding children’s unit for information sharing.
There are good safeguarding practices carried out by the minor injuries unit (MIU). This innovative practice has been put into place in all minor injury units across the county. The service has introduced triggers following the frequent use of the service by some individuals. The units monitor people who use the service more than three times in a month. Assessments of these visits are carried out by the children and adults safeguarding team and liaison with the GP and other professionals is made. This is providing early intervention to chaotic families and has highlighted vulnerable children. Health partners aim to establish this system within the accident and emergency service.

The ambulance service has implemented a similar scheme whereby if there is a frequency of six call outs in a month by an individual, these are then reported and the person's GP is informed. The ambulance service is experiencing similar outcomes to the MIU incentive.

NHS Cornwall and Isles of Scilly have worked with the young people's drug and alcohol joint commissioning group to commission a drug and alcohol liaison nurse to be based within the accident and emergency service. Recruitment processes have commenced; once in post, this will ensure that children and young people will be seen by appropriate professionals.

**Partnership working**

Partnership working is inadequate, staff reported that the interpretation of the thresholds for safeguarding are inconsistent and that they have experienced difficulties when referring safeguarding issues to social care. This has resulted in named safeguarding leads discussing referrals more frequently with social care resulting in delays in actions taken where needed.

Since the comprehensive restructuring of children's services in September 2008 to be completed in January 2009, there has been a level of confusion in relation to roles and actions taken by social care. The NHS has ensured that their processes for safeguarding are robust and that staff are aware of their roles and actions to be taken.

There are regular Prevention Panels held in the three locations of Cornwall [East, West and Mid]. These are multi-disciplinary and discuss where individual child's needs are being met through the Team Around the Child [TAC], decisions are made about how this should be managed and lessons learnt are shared. As the leads for a number of TACs are health visitors and school nurses, this has enabled the PCT to make changes ensuring that effective care and support are available.

**Clinical leadership**

All staff interviewed were positive about clinical leadership. Staff at different levels of management reported that they offer and received good support and supervision.
They also reported that the named safeguarding leads are available to offer guidance and support.

**Training and supervision**

Each NHS trust has mandatory training policies in place which cover training in safeguarding. The policies include needs assessments, which identify which staff need what level of training, providing clear directives to managers. The trainers reported that all staff undergo level 1 child protection training at induction. The use of an e-learning package, ‘Moodle’ is reported as being very popular with staff and has improved uptake of child protection training. Managers check this training during supervision.

The take up of level 1 and 2 child protection training for midwives is good with good attendance at CAMAT. Mental health workers also reported they have had level 1 training with staff at band 6 and above receiving level 2 training. Children and family service administrators also complete level 2 training.

Training of other staff who have contact with children is varied. Surgeons and anaesthetists who operate on children have all received child protection training, and there is a plan to have all staff trained to the agreed appropriate level within 3 months. The clinical strategy is to develop a dedicated children's theatre suite by March 2010.

Various staff told us that they received supervision and felt supported by the safeguarding leads when making decisions about how to proceed.

**Contracts and performance management**

Contract and performance management of services has improved recently with more formal arrangements in place. Improvements are being made to services as a result, however as this is a recent change the auditing of improvements and their sustainability has not been established. For example, improvements in the waiting time from assessment to delivery of basic equipment for children and young people who are disabled have improved. The Child and Adolescent Mental Health Service is still not fully established; however, one of the improvements has been the introduction of primary mental health workers who support CAMHs in addressing mental health issues and early intervention.

**Assessment, referral and case planning systems**

There has been an increase in the utilisation of the common assessment framework [CAF] and training for all areas of health. Health visitors and school nurses reported that they are involved as the lead practitioner for a number of these cases.

Midwives apparently complete CAFs as a need is identified, however there is some reluctance to do so and complete a pre-CAF for every pregnant woman regardless of
need. There is a project underway to determine the feasibility of using the CAFs and to ascertain if the pre-CAFs are more suitable until the birth of the child.

There is a bespoke Forensic Unit that is now used by all cases in Cornwall referred for safeguarding where there is an allegation or actual incident of sexual assault or abuse. It has the facility to carry out colposcopy, and staff have had training in collecting evidence according to forensic medicine. The team work closely with the police and the feedback is that children using this unit are less scared and intimidated.

There has been an improvement of the delivery of basic equipment to children with physical disability, however, the process for assessment and receiving more complex equipment remains poor. Parents told us that the equipment service had improved although for the more specialist equipment home delivery was not possible.

**Key findings – Looked after children and health**

*Extract from inspection report of safeguarding and looked after children services – Ofsted October 2009*

The inspection has identified failures in compliance including those for care planning, risk assessment, review, recording, permanency planning and social worker visiting.

Although the political and managerial leadership across the council and partner agencies expresses clearly their ambition and commitment to service improvement, this has yet to be translated into improved and strengthened services for looked after children and care leavers.

Performance in accessing initial health assessments carried out within 28 days has significantly improved from 30% to 90%, however a lack of information-sharing between children’s social care and health colleagues has resulted in only 63% of looked after children aged 0–5 years and 16% of children and young people aged five and over receiving their annual health checks within time.

Despite countywide difficulties within Cornwall for people to access dental services, this has not been the case for looked after children. Significant effort has been made within the health community since the joint area review in 2008 to address this issue resulting in 87% of looked after children and young people receiving appropriate dental services.

Preventive health care arrangements are good with immunisation rates up to date and a 76% take up rate of substance misuse services by those looked after children who are assessed and offered a service. Due to the shortage in some areas of named nurses for looked after children health visitors have to undertake this role.
Progress across Cornwall in establishing a cohesive CAMHS is inadequate and has resulted in looked after children not having direct access to a specifically designated CAMHS. Instead, each looked after child referred to the service is seen and assessed by a psychologist within five days of referral and a decision made as to whether they meet the threshold for CAMHS. Where assessment identifies that alternative form of therapy is the most appropriate course of action, there are no specifically designated resources available to looked after children. Such services are commissioned by children’s social care and there are examples where this has occurred, however there are no performance monitoring arrangements in place to assess whether these services are consistent or effective in producing improved outcomes for children and young people. It is of concern that where looked after children are admitted to hospital as a result of self-harm they are seen by the CAMHS but are not routinely taken on or referred to the psychology service. The designated doctor and nurse for looked after children are not consistently notified of these episodes and often have to rely on foster carers to provide them with the information.

Leadership and management of services for looked after children are inadequate. Although there is an expressed commitment across the partnership from key agencies to deliver improved outcomes for looked after children and young people it has not been translated into practice.

Overall Being Healthy grade - adequate

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**Partnership working**

There is evidence to show that the commissioning PCT is working with other health partners to improve the health and wellbeing of children and young people who are looked after. Health partners are committed to making sure children and young people receive a good health service with some outcomes now showing improvement.

The designated doctor for Children in Care has been in place since October 2008 and improvements to the looked after children’s nursing team are now being implemented with additional nursing resource provided. A designated nurse for Looked After Children will commence their role in November 2009. Changes to the way services are provided have resulted in six clinic locations across the county now being available to ensure 90% of children and young people are seen within 28 days of becoming looked after. Children and young people are also seen by the same professional within these settings to ensure continuity.

Lack of information sharing between partners remains a key issue. Information sharing and communication, following admission of a looked after child, from the hospital to the looked after children’s health team needs to be improved. Information sharing
between social care and the Looked after Children’s Health team continues to be a key issue; there has been some recent improvement which is helping to ensure initial assessments are carried out promptly; the follow up assessment are being completed but these are not always in a timely manner.

Contracts and Performance Management

Commissioning arrangements for looked after children and young people have improved with more robust arrangements in place.

Significant effort has been made within the health community since the joint area review in 2008 to address the areas for improvement. Access to appropriate dental services is good and there are good arrangements in place that ensure immunisation rates are up to date and young people have good access to substance misuse services.

However, due to the shortage in some areas of school nurses means that health visitors have had to undertake the role of named nurse for school age children. Health visitors are not able to carry out other work with families in relation to support and prevention. Training has commenced to ensure that there are more school nurses available in those areas in Cornwall where there are gaps.

Progress in establishing a cohesive Child and Adolescent Mental Health Service is inadequate and has resulted in looked after children not having direct access to a specifically designated CAMHS.

Areas of Strength

All of the staff spoken to demonstrated a commitment and willingness to improving services. Good progress has been made within the health communities to ensure staff; including general practitioners, receive the appropriate level of safeguarding training. Within health there are now robust recording systems in place to track and monitor the uptake of child protection and safeguarding training.

Relevant Recommendations for Improvement from joint report

- Ensure agreed arrangements for the implementation of the Child and Adolescent Mental Health Service are completed and that the service is fully functional and provides specifically designated direct provision for looked after children and young people. This is an outstanding recommendation from the joint area review in 2008.

- Ensure there is sufficient capacity to support preventative work on substance misuse and review transition arrangements between children’s and adult services for young people with substance misuse difficulties.
• Ensure that when looked after children and young people are admitted to hospital as a result of self harm that the designated doctor and nurse are provided with full details of their admission and any subsequent treatment plans.

Additional recommendations for improvement

• Ensure there are sufficient school nurses and health visitors to ensure that preventative work can be carried out effectively and can be sustained.

• Ensure that improvements are made in the carrying out of yearly health assessments for looked after children. These should be completed within 4 weeks of the yearly date for assessment.

• Ensure that assessment, choice and delivery of equipment needed by disabled children is more efficient and that parents and children can have a choice and trial equipment where needed.

Conclusion

Your CQC Regional Director is copied into this letter and will arrange follow up on any actions detailed. We have also copied in the Strategic Health Authority and CQC’s Head of National Inspection and Assessment, who has overall responsibility for this inspection programme. In respect of the recommendations, please complete an action plan detailing how they will be addressed and submit this to our regional director and your SHA Chief Executive within 20 working days of receipt of this letter.

Yours sincerely

Charlotte Trimm
Project Manager, Children’s Service Inspections
Operations Directorate

Cc
Sir Ian Carruthers – Chief Executive – SHA - NHS South West
Mr Ian Biggs – CQC Regional Director (South West Region)
Mr Nigel Ellis – CQC Head of National Inspections and Assessment
Mr Chris Batty HMI – Ofsted Managing Inspections
Ms Lynne Staines – Ofsted Lead Inspector
Other organisations involved in this review

Royal Cornwall Hospitals NHS Trust
Cornwall Partnership NHS Trust
Cornwall and Isles of Scilly Community Health Services