

Inspection Report
Integrated Inspection of Safeguarding and Looked After
Children's Services in Essex –
West Essex PCT and Princess Alexandra Hospital NHS
trust
And North Essex Partnership NHS Foundation trust

Date of Inspection	28 June – 9th July 2010
Date of final Report	6 August 2010
Chief Executive	Catherine O'Connell
Organisation Name	West Essex Primary Care Trust
Organisation Address	4 Spencer Close, St Margaret's Hospital, The Plain, Epping, Essex CM16 6TN
CQC Inspector name	Patricia Hellier

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: [The joint inspection report](#)

This report includes findings from the overall inspection report, and provides greater detail about the findings from CQC's components of the inspection mapped where relevant to the Essential Standards of Quality and Safety, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your CQC Regional Director who will arrange follow up on any actions detailed in the report. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's head of national Inspections, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included in italics where relevant.

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

This document sets out the findings specifically for the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

The Context

Commissioning and planning of health services are carried out by five Primary Care Trusts (PCTs) based in the west, mid, north, south west and south east areas of the county; this inspection focussed however on the three Northern PCTs, being North East Essex, Mid Essex and West Essex PCTs. Acute hospital services included in this inspection are provided by Mid Essex Hospital Services NHS Trust, The Princess Alexandra Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust.

Learning disability services are provided by Essex County Council, South Essex Partnership University NHS Foundation Trust, North Essex Partnership NHS Foundation Trust and the five Essex PCTs. Adult mental health services are provided by South Essex Partnership NHS Foundation Trust and North Essex Partnership NHS Foundation Trust, and Child and Adolescent Mental Health Services (CAMHS) are provided by North Essex Partnership NHS Foundation Trust and Essex County Council

1 General – leadership and management

1.1 The five PCTs in Essex (of which three were inspected specifically) commission and currently provide healthcare for the children and young people of Essex. Each

PCT is working to separate their provider arm in line with “Transforming Community Services” and it was anticipated at the time of Inspection that the commissioner arms will move to merge, wholly or partially over the next 15-21 months. The implications of forthcoming national policy changes relating to commissioning are still to be determined.

1.2 The Essex Children’s Trust was formally launched in December 2009 and governance, structures and implications are still being communicated across the partnership. For many partners this will require changes to established ways of working and increasing external liaison and scrutiny; combining this with a number of changes to local authority services, (for example, the relaunch of the CAF arrangements in April and new protocol for access to CAMHS) has resulted in some NHS staff feeling anxious and less informed than others about current procedures.

1.3 Development of a cohesive health partnership within the Children’s Trust is led by a Chief Executive and a Nurse Director from the two PCTs in the South of the county, which are linked to unitary authorities and were not included in this inspection. The group responsible for driving forward change, and for the development of a joint commissioning unit, comprises officers at Commissioner level within the PCTs, rather than Chief Executives. The level of influence, authority and corporate stakeholder backing contributed by these individuals appears to be insufficient to fully engage staff groups within each partner PCT at this critical stage of development.

1.4 There are a large number of subcommittees contributing to the Children’s Trust and ESCB, both across Essex and within localities. Whilst PCT boards appear to be fluent in navigating the arrangements there is a lack of clarity of governance and decision making responsibility which is impeding communications and implementation of developments across health partners

1.5 Currently, not all members of the ESCB executive board are of an appropriate level of seniority to influence and drive forwards the priorities and work of the ESCB their own agencies. This is a particular issue within the five PCT who all operate independently. Membership is currently being reviewed but at the time of inspection health partners had not all nominated persons of an appropriately senior status.

1.6 Currently, across health partners countywide there is a lack of strategic vision to consolidate the safeguarding arrangements for children and young people. The Children and Young People’s Plan 2009-11 fails to address and prioritise the seriousness of the failings in safeguarding services

1.7 A proposal for a Joint Commissioning Unit has been agreed in principle by the partner PCTs but arrangements for governance, financial analysis, communications and timescales have not yet been examined in detail and the implications for changed ways of working and the pace of implementation do not appear to be recognised at or below board level.

1.8 [However] within the wider health community, risks associated with the proposed structural changes to provider community functions have not been sufficiently well

identified. Workforce planning, safeguarding responsibilities and governance have yet to be addressed.

1.9 The Joint Strategic Needs Analysis does not sufficiently reflect the vision for healthcare across Essex; it details the current situation but there is insufficient analysis of trends and projections to enable effective planning across health and council services.

1.10. The three public health directors in North Essex work closely with the Council - one is a joint appointment – and between them chair or attend subcommittees of the Children’s Trust and chair the Child Death Overview panel.

1.11 The PCTs are working independently in their approach to Transforming Community Services with five different models of community provision being pursued for April 2011 across Essex. This is potentially inefficient and unsettling for staff and there is insufficient acknowledgement or risk analysis at Commissioner Board level within the inspected PCTs of the safeguarding implications of poor staff morale and complex contractual and governance arrangements in the new providers.

1.12 Safeguarding and LAC policies and procedures at commissioner and provider board level are good. The PCT commissioners use a range of key performance indicators (KPIs) to oversee progress in safeguarding, building on the findings of the SHA’s Intensive Support Team (IST) visit in early in 2010.

1.13 Arrangements for Safeguarding and management of LAC are currently determined locally, by each PCT with consequent inconsistencies of approach and pressure on staffing and leadership, particularly for named and designated professionals. There is amongst some staff a vision of a joint safeguarding “hub” but commitment is insufficiently demonstrated, eg separate recruitment procedures for the designated doctors.

1.14 The engagement of primary health teams within children’s centres is improving access to health and lifestyle information and support, particularly for young parents and families and the sexual health teams are reaching young people effectively through a range of drop-ins in appropriate settings.

1.15 The “Team around the Child” initiatives have been established in the three PCTs and are working well although hampered by difficulties with social services resources and response times.

1.16 The service for equipment and aids across Essex is inadequate at present, with a range of sources for equipment, long waits and a lack of clarity amongst stakeholders of how to access the service.

1.17 The “Equip” audit of GP provision was well received and a number of initiatives have resulted such as improved recognition of the needs of young carers. However, overall progress in training and involving GPs in safeguarding activity is patchy; West Essex have three named safeguarding GPs but the posts in Mid Essex and North East Essex are vacant.

1.18 Within the acute and mental health provider services inspected, there are generally good procedures for safeguarding and clear understanding by staff of their responsibilities.

1.19 The quality and comprehensiveness of health and educational support for looked after children, young people and care leavers are adequate. Health assessments across the county are conducted by a range of health professionals and results in the variable quality of health assessments. Looked after children and young people are positively encouraged to pursue healthy lifestyles and broaden their horizons through leisure and cultural opportunities.

1.20 There is a good range of specialist mental health and substance misuse services including a drug and alcohol outreach team available to looked after children and young people. These services are accessible and take up is good. A fast track Child and Adolescent Mental Health Service (CAMHS) for looked after children, young people and care leavers provides flexible services to parents and carers and individual therapeutic support to looked after children and care leavers. This resource is highly valued by carers and young people alike.

2 Outcome 1 Involving Users

2.1 Involvement of users across the health partnership is underdeveloped and whilst there are a number of effective and enthusiastic localised initiatives there are no systematic programmes of engagement at commissioner or provider level.

2.2 Work with young people leaving care and those aged 16-18 years is poor, as it is the only trust in the area not to have a young people's health advisor. Specialist staff have developed a range of initiatives to address sexual health, contraception, alcohol and substance misuse needs. Communications systems with IRO are not working and the voice of children and young people is not accessed routinely or in transition arrangements. Partnership work, for example, work in supported housing areas is effective and valued but there is insufficient evidence of improvement in outcomes which makes these services vulnerable.

2.3 The One Stop shop in Harlow Town Centre (which is the main centre in West Essex) provides a more comprehensive service for young people than in other areas, giving the opportunity to access health care advice, consultations with various professionals and Health promotion information. The Sexual Health advisor from the Waltham Abbey Young Peoples Information Centre has been relocated back into health premises at the request of young people because the young people felt that confidentiality was better achieved through this location. Both facilities provide young people with an opportunity to access health care advice, consultations with various professionals and health promotion information. They provide a targeted resource for young people seeking health support and advice in an environment in which they feel comfortable.

2.4 Access to services for those who do not speak English is supported by availability of Language Line and/or translators and staff generally felt comfortable

using this resource, although in acute units other staff who speak the relevant language would usually be used.

2.5 Within health there are examples of where users have informed specific service development and delivery. However, there is no co-ordinated and strategic approach across the PCTs as a whole for service users to inform service planning and delivery to meet more appropriately the needs of the children and young people and to involve and engage them routinely in service delivery.

2.6 [Young carers] consider that general practitioners (GPs) across the county are not all sufficiently aware of support available to young carers and therefore do not routinely ask parents and carers with complex needs about their dependent children who may benefit from the support of the young carers' team. Within health their concerns are being addressed by health partners, and good progress has been made in identifying young carers by health partners.

3 Outcome 4 Care and welfare of people who use services

3.1 CAMHS services for the inspected organisations are provided by North Essex Partnership NHS Foundation Trust at Tiers 3 and 4 and the Authority provides a Tier 2 service. This tier 2 service has recently undergone a reconfiguration with the introduction of a pilot known as Brief Child and Family Phone Interview. This is "telephone triage" with clear thresholds for intervention, and information on these arrangements is still being disseminated resulting in some uncertainty amongst practitioners as to the current arrangements. This project will be externally evaluated in December 2010. Until recently there was a lack of capacity in the service and inappropriate referrals were sometimes being made to Tier 3 to obtain urgent assessment and support.

3.2 Inconsistencies were reported when referring young people with special needs for CAMHS support, with any referrals for children with special needs being placed within a general waiting list but those referrals for young people with special needs who attended specialist education provision being "fast tracked."

3.3 The Mother and Baby Unit serving the northern PCT's is located adjacent to Mid Essex Hospitals NHS Trust. It is currently undergoing refurbishment and expansion to make sure that the environment and service provision is suitable for the safe care of mothers and their babies and is due to be operational in September 2010.

3.4 The Essex Young People's Drug and Advisory Service is third sector provision based in Chelmsford. The service is well regarded, providing a timely and effective support to young people.

3.5 School nurses provide an enthusiastic but overstretched service across the area, but there is a severe lack of capacity which restricts their availability for health promotion work.

3.6 The West Essex PCT have introduced case management through skill mix as a way of addressing staffing deficits within health visiting. The health visitors carry out the work on the more complex cases and are supported in the universal provision by

community nursery nurses and community staff nurses. The effectiveness of this approach has yet to be evaluated. However this has not addressed the issues that health visitors in some areas of West Essex are required to maintain excessive caseloads that include high numbers of vulnerable families.

3.7 Sexual Health services are good, with enthusiastic initiatives in each PCT around Chlamydia screening and contraception. In particular, the outreach service provided by West Essex PCT is actively engaged with schools and colleges and the local communities.

3.8 The under 18 conception rate for West Essex has shown a decrease, however, the area still has high teenage conception rate compared to its neighbours and the national average. It is recognised that the PCT have commissioned a number of initiatives to address the high numbers of young people who become pregnant in West Essex and this work will need to continue with careful evaluation to demonstrate positive outcomes.

3.9 Arrangements for support of teenagers who are pregnant or are parents is adequate. The West Essex Teenage Support Service based in Harlow provides advice and support to young fathers as well as mothers. The service works well with partners, including Connexions and reports good success in encouraging young people back into education, training or employment.

3.10 There is a lack of clarity across the partnership over the experience and follow up of those young women who have chosen a termination of pregnancy. In West Essex contact numbers are given to all women and follow up appointments offered.

3.11 The parents interviewed described long waits to access the speech and language therapy services, with waits of 18 weeks and six months quoted. A further source of frustration was the length of time between appointments, usually at intervals of 4 to 6 weeks. While the latter may be therapeutically appropriate parents are not always aware of this.

3.12 The quality and timeliness of initial health assessments for LAC in West Essex is inadequate. The assessments are, in the main, carried out by the general practitioners in their surgeries. The quality is very varied and not often timely. Young people have expressed their dislike of attending a GP surgery for assessment. The service would benefit from having the health needs assessments being led by doctors who have paediatric experience in this field especially as a significant number of LAC are under the care of community paediatricians and/or receive hospital follow up.

3.13 Immunisation rates are adequate with 76.8% of the LAC up to date with their immunisation programme however this is lower than the national average but is thought to be affected by the numbers of unaccompanied asylum seeking children. 87% of LAC are registered with an NHS dentist and have received timely dental checks. Review health assessments are undertaken by health visitors (for the under 5's) and school nurses who have received specific training in respect of the need of LAC and 97% are completed within target timeframes. Health visitor and School

nurses build links with foster families and provide foster carer support and training through network groups.

3. In West Essex LAC with complex care needs receive an outstanding service. All are referred to a specialist community paediatrician who has a keen interest in ensuring their needs are appropriately met by undertaking their initial and review health assessments. Their care is then followed up in collaboration with the Designated Nurse. The paediatrician also sits on the adoption panel and fulfils a key liaison role in the appropriate placing of these young people.

3.15 In West Essex provision for unaccompanied asylum seeking children is well managed, with specific attention given to public health issues regarding diseases from countries of origin and immunisations required.

3.16 Overall health provision for looked after children and care leavers is adequate. There is a lack of consistency between PCTs in the provision of health input to looked after children, young people and care leavers. The service is insufficiently resourced to meet need. The inspection identified this as a particular issue in West Essex PCT

3.17 Most children and young people who responded to the pre-inspection Care4me survey report they have a healthy diet and receive good support to sustain a healthy lifestyle. There is a good take up of opportunities by looked after children to learn to cook and eat well. Gym membership, healthy eating and activities to build confidence and self esteem are actively encouraged for care leavers. Negotiations with district councils have resulted in concessionary or free leisure passes to encourage engagement in a wide range of sporting activities. In Mid- and North East Essex PCTs effective work is undertaken by specialist health advisers for looked after children and care leavers aged 15-19 years of age to promote good health advice and guidance. Consequently an increasing number of young people are electing to receive appropriate health advice, take up immunizations and receive sexual relationship education. However, such advice and guidance is dependent upon which PCT area the young person is living in and therefore there is inequality of access across the county as a whole.

3.19 In some instances the lack of capacity impacts adversely on the timeliness and the quality of the annual health checks for looked after children. Children's social care do not consistently provide core information to the looked after children's teams within health to enable the completion of a holistic assessment. On occasion the authority omits to obtain and/or forward a signed parental or guardian consent to treatment. In some cases inspected it was clear that work has been undertaken to raise the quality of initial health assessments and health care plans. However, practice is inconsistent and is not being developed on a countywide basis using appropriately trained medical professionals. Some initial health assessments are carried out by GPs and some by community paediatricians with annual health assessments carried out by nurse practitioners or school nurses. The lack of a coordinated approach and consistency in practice reduces the opportunity for there to be an overall picture of the health needs for looked after children and reduces the opportunity to influence service planning

4 Outcome 6 Co-operating with others

4.1 Involvement of partners in Essex Safeguarding Children Board (ESCB) and the Children's Trust is not co-ordinated and joint representation is at an early stage as the governance arrangements of the two bodies become clearer.

4.2 [Previously] there was little evidence that statutory partners were working together to share their respective responsibilities and accountability to contribute positively to safeguarding children

4.3 Health engagement in training of foster carers and children's home staff including the principles of healthy care for children and young people was patchy, and depends upon local initiatives rather than a co-ordinated programme across the Authority. In West Essex the "Putting Children First" project has enhanced health professional's engagement with foster carers and families through the advertising of the initiative in all health and care areas which includes key contact details to access specific information and support.

4.3 There is limited health input into the training and support of foster carers to help prevent breakdown. Placement stability is good and supported by a good range of outreach services and through direct work by professionals with foster carers such as that provided by CAMHS, substance misuse services and in Mid and West Essex PCT areas, the specialist health advisers for 15-19 year olds.

4.4 Healthcare arrangements for looked after children placed out of area are increasingly being negotiated in advance through the Joint Area Panel. Within Essex there is no cross-charging but more work is needed to ensure effective pre-placement contracts are negotiated for placements further a field. Children and young people who are placed out of area need to enjoy the same provision of healthcare as their peers in county.

4.5 The looked after children's nurses are responsible for arranging health checks for those who are placed out of the county but there is not a clear system for coordination and these arrangements are often negotiated on an individual basis.

4.6 There is good awareness in West Essex and across the partnership of the implications of domestic violence following recommendations from a previous Serious Case Review (SCR). The appointment of a specialist nurse for domestic violence and the support provided by named health visitors who have a lead in working within the refuge network locally as well as managing their normal caseload has increased communication across partners and staff knowledge and awareness of management of such situations. Staff across all provider services are clear what to do if abuse is suspected. In recognition of the importance of this work the acute trust has a named midwife who leads on MARAC and has domestic abuse as part of her job remit.

4.7 At Princess Alexandra Hospital there is increasing reporting of concerns about attendance of adults with self harm or substance misuse where there are children in the family. There were good links with the drug and alcohol services with joint visits and joint clinics taking place.

4.8 Work with the Youth Offending teams is generally good with dedicated substance misuse posts and good links between YOT's and universal health services

4.9 West Essex GPs contribution to case conferences is limited and the absence of a named GP for the area is impeding progress in this area of essential work

4.10 The assessment of the needs of vulnerable children using the common assessment framework (CAF) is adequate and was re-launched in April 2010. Previously there was inconsistent engagement in the use of CAF by partner agencies particularly within health communities

4.11 There is inconsistent understanding and use of CAF across health partners; whilst the Children's Trust is working steadily to standardise and embed the process, health managers should be taking a more active part in designing the system and its rollout so that it effectively meets the requirements of partners and is "owned" by all staff. Awareness of MAAG is increasing, particularly in Harlow, where health staff are aware of the benefits of referral and the appropriate designation of the lead professional role.

4.12 Transition arrangements from children's services into adult services are limited with no joint assessments undertaken and the transition pathway is underdeveloped or non-existent. For young people with a disability and those with complex needs they often pass between the learning disability and mental health teams which do not protect their dignity and mental/emotional health and well-being. Children and young people are not always kept safe at transition stage.

4.13 Referrals to CAMHS lack clarity of threshold and some staff are not yet aware of the new pilot for the triage-based arrangement for referrals, resulting in an oversubscribed Tier3 service. The pilots are being carried out in small cohorts and this is currently only in schools in Harlow.

4.14 The sexual health teams are reaching young people effectively through a range of drop-in settings. The sexual health service is effective with good cross team working across the three PCTs. However, not all schools follow the guidance in relation to the delivery of sex and relationship education in schools and this may have a detrimental effect on the partnership's ability to reduce teenage conception rates. For example, one school that does not subscribe to any external support has recently had three unplanned teenage pregnancies and in another part of the county a school experienced an increase in alcohol related sexual assault. Currently, there is inadequate provision for the examination of children and young people who may have been victims of sexual assault. The partnership has plans to resolve the deficit and a sexual assault referral centre is due to become operational but not until April 2011

4.15 Partnership working across both statutory and voluntary sectors to safeguard children from domestic abuse is satisfactory. Staff across all agencies are aware of the risks to children and take steps to be proactive. For example improved assessment processes within maternity services in North and West Essex ensure

risks to and support for pregnant women are appropriately identified and delivered. Consistency of agency practice across Essex has yet to be fully achieved. Within the health community, GPs, health visitors and school nursing identify a lack of training in domestic abuse as an important deficit. Multi-Agency Risk Assessment Conferencing (MARAC) arrangements are well-established with an appropriate level of representation from partner agencies.

4.16. The 'Think Family' multi-agency training programme is stimulating improved joint working within substance misuse programmes

4.17 The engagement of primary health teams within children's centres is improving access to health and lifestyle information and support for young parents and families.

4.18 There is a good example of a co-located health visitor within a children's centre in one of the most deprived areas in West Essex that promotes trusting relationships and earlier support and intervention to safeguarding children and young people.

5 Outcome 7 Safeguarding

5.1 There is poor co-ordination across health partners of the safeguarding doctor role resulting in inconsistent job descriptions and communications arrangements between safeguarding leads. Recruitment is under way for two separate designated doctor positions to work across commissioners but there is no formal, contractual connection.

5.2 There are shortages in named nurse and doctor provision across the inspected organisations, and whilst some post holders are individually providing a robust service in specific areas of the county, this is unsustainable without the correct complement of senior staff in place. West Essex Community Health Services are currently restructuring the safeguarding children and families team which will enable extra capacity to be built into the Named Nurse role.

5.3 The CDOP is not currently working effectively but will be developed as the Children's Trust and ESCB become more established. Chaired by one of the three Directors of Public Health, it currently oversees five local review panels which conduct the majority of the analysis.

5.4 At Princess Alexandra Hospitals NHS Trust reviews of any deaths of children under 16 are led by the paediatric consultant; those for deaths of young people between 16 and 18 are led by the A&E consultant as part of the Child Death Rapid Response team to ensure that appropriate clinical skills and knowledge are drawn on and ensure good understanding of the reasons for death. Thus key and appropriate learning can be drawn out for dissemination to clinicians to enhance service responsiveness.

5.5 Provision of a Sexual Assault Referral Centre (SARC) has been significantly delayed but is now on track to open in January 2011. Services are currently inadequate and young people face long and often traumatic delays for assessment

to be arranged. Consultant paediatricians have been reluctant to participate in this work, resulting in considerable delays to implementation of the new service. This is not acceptable and the current proposals for resolution must be robustly implemented by trust managers. Consultant paediatricians and management at Princess Alexandra Hospital have been engaged with the ongoing SARC project and have identified current job plans do not have the capacity to incorporate the time required to provide cover for the SARC. In the interim the trust has a protocol in place for the management of sexual assault however this provision is not adequate and does not fully meet the requirements,

5.6 Arrangements for recognising and supporting victims of domestic abuse have been strengthened following a recent SCR. A comprehensive training programme has been delivered across health partners. There is no evidence as yet on the impact of this work.

5.7 The accident and emergency units in the three inspected acute trusts across the county have effective systems in place to monitor repeat attendance and children who are the subject of child protection plans.

5.8 All staff in A&E have good knowledge of safeguarding training and there are clear prompts on all paper work to assist staff in asking the key questions of both adults and young people. A flow chart for all steps in the safeguarding process is used in every set of notes (where concerns are identified) with each section being signed off by the completing practitioner to ensure clear information flow. Staff have a good understanding of thresholds and referral processes. They report a mixed response from social care colleagues with difficulty in information sharing at times. However they do believe it is improving,

5.9 At Princess Alexandra Hospitals NHS Trust close observation of young people is sometimes be carried out by security staff who may not have undergone the required checks to ensure they do not potentially pose a risk to children and young e.g. the trust is unsure if they have current CRB enhanced clearance. This practice should be urgently reviewed

6 Outcome 11 Safety, availability and suitability of equipment

6.1 Although there is a joint process applicable to both health and social care for the ordering of equipment and adaptations for children with disabilities, parents and carers do not fully understand the system and perceive practice to be variable across the county. The current system is confusing and while children's needs are individually met it is not without added frustrations for parents.

6.2 The paediatric A&E unit at Princess Alexandra Hospital NHS Trust is a dedicated enclosed area within the main secure A&E department.

6.3 The entrance to the paediatric A&E facility is not secure and this poses a risk for staff, children and young people. The paediatric resuscitation area is one bed within the main resuscitation area and is often utilised by the main service without the knowledge of the staff working in the paediatric A&E and this is unsafe as it and the

equipment may not be available when required to meet the health needs of young people

7. Outcome 13 Staffing numbers

7.1. Within the community NHS providers there is a severe shortage of health visitors and school nurses and whilst there have been attempts to mitigate the risk through skill mix and recruiting additional support staff, resourcing remains inadequate and the service is insufficient to fully safeguard the needs of children and young people. Similarly there is an insufficient number of designated doctors and nurses in post across the county to meet the need for an efficient and effective safeguarding service.

7.2 Health communities have yet to review and address the lack of capacity within health visiting, school nursing and the designated doctor and nurse roles. Capacity issues remain within health visiting, school nursing and the designated safeguarding doctor and nurse sectors and this is an important weakness

7.3 Staffing constraints have resulted in elements of the Healthy Child Programme not being delivered across the partnership.

7.4 Capacity in therapy services within some provider services is poor, for example Speech and Language Therapy is limited with private assessments being funded across the whole of Essex, although plans are in place to review these arrangements and redesign the service.

7.5 The capacity of the LAC nursing team in West Essex needs reviewing. There are a large number of looked after children who are the responsibility of West Essex health services and limited time and resources of the designated to nurse to provide an adequate service for the benefit of young people..

7.6 The skill mix of A&E staff within Princess Alexandra Hospital NHS Trust is inadequate. There are insufficient numbers of paediatric qualified staff within the unit and this means children are assessed by staff that have not had the necessary paediatric training potentially putting them at risk of inadequate or inappropriate care.

8 Outcome 14 Staffing support

8.1 Safeguarding Supervision arrangements are generally effective and staff report feeling supported in their work.

8.2 Good progress has been made in ensuring that within the health community, safeguarding training at Levels 1 and 2 has been delivered. However, all health organisations inspected are not compliant with Level 3 safeguarding training.

8.2 Level 1 Safeguarding training is provided on induction by all Essex health partners. Level 2 training is conducted by e-learning or face to face and is provided to all staff who may have contact with children. Level 3 training is provided to staff

that work mainly with children and implementation is behind schedule in both the provider of community services and Princess Alexandra Hospital NHS Trust. Training at level 3 is designed and provided by individual providers since the LSCB cannot resource a relevant level 3 package, and the content needs to be rechecked to ensure that it meets the criteria for competencies under the Intercollegiate Guidance (RCPCH). This has been referred to the Children's trust Board.

8.3 Uptake of safeguarding training by GPs within West Essex is low and this needs addressing urgently.

8.4 The workforce in West Essex provider services are uncertain about the transition to become independent bodies by April 2011. It is not clear that sufficient resources will be negotiated to provide safe levels of staffing to support the (universal) Child Health programme, as well as the safeguarding agenda.

8.5 Development of the children's workforce is limited by the lack of a joint workforce strategy established across partner agencies. A one workforce implementation group has recently been re-launched but it is too soon for impact to show.

9 Outcome 16 Audit and monitoring

9.1 West Essex PCT monitors the performance of its providers through a range of Key Performance Indicators (KPIs) which feed the clinical quality groups, finance and information groups and the quarterly performance management group. Progress has been adequate on taking forward the recommendations of the IST review in February 2010 and the action plan is monitored regularly.

9.2 Within health, commissioners have included well thought out key performance indicators as part of detailed service specifications and these are used effectively in the monitoring of contracts. There is good use made of exception reporting at PCT Board level across the three primary care trusts inspected.

10 Outcome 21 Records

10.1 The introduction, following a Serious Case Review, of a bespoke proprietary IT system to link children's services and health partners is progressing slowly but staff awareness of, and confidence in the new system as it rolls out is patchy and there was inconsistent understanding of the benefits of the new arrangements.

11 Recommendations

Within 3 months (italics are recommendations from joint report)

Essex PCTs to ensure appropriately trained individuals undertake health assessments and implement a robust monitoring system to ensure consistent good quality assessments.

- *Essex PCTs to provide clear and effective leadership for safeguarding of children and young people through clearly defined and substantive designated and named nurse and doctor roles, building teams working across the health communities*

- Essex PCTs to demonstrate a co-ordinated and strategic approach to involving people who use services in the planning and delivery of services targeted to children and young people, including those children and young people that are looked after.
- West Essex PCT to ensure that there is a clear pathway for the provision of essential equipment to children and young people with disabilities.
- West Essex PCT and Princess Alexandra Hospital NHS Trust to ensure that children and young people who attend accident and emergency receive care in an environment that is staffed by appropriately trained healthcare professionals.
- The Princess Alexandra Hospital NHS trust to ensure that all staff who provide close supervision for young people have full safer recruitment checks undertaken and verified for the protection of young people.

Within 6 months

- *The Boards of Essex PCTs to demonstrate that the partnership priorities agreed with the Children's Trust Board and the Essex Safeguarding Children Board are embedded and outcomes improve throughout the Essex health economy.*
- *Essex Safeguarding Children Board and health partners to ensure Group 3 interagency and level 3 health safeguarding training is commissioned and provided to meet need and accords with the guidance given in 'Working Together to Safeguard Children – 2010'*
- *Essex PCTs to ensure there is sufficient capacity within health visiting and school nursing services to provide universal and targeted services to safeguard children and young people in Essex, both currently and during/after the planned separation of provider services.*
- *To ensure that provision for examination and support for children and young people who may have been sexually assaulted is responsive and effective, with a sufficient complement of medical expertise.*
- *Essex PCTs to review and address lack of capacity and consistency of practice across the county within the looked after children nurse service.*
- * Essex PCTs to ensure that transition arrangements for children to adult services facilitate co-operation across teams to ensure that the services provided continue to be appropriate to the age and needs of the young person involved. .
- * Essex PCTs to ensure that there is an integrated, agreed IT strategy which satisfies the recent recommendation from a serious case review to link children's services and health partners across Essex.

- * West Essex PCT to ensure that the General Practitioners have access to and can demonstrate completion of safeguarding training as outlined in the guidance “Working Together to Safeguarding Children 2010.”

12 Next steps

An action plan is required within 20 working days of receipt of this report. Please submit the action plan to your SHA lead, copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.

Other organisations involved in this inspection

North East Essex Primary Care Trust
North East Essex Provider Services
Mid Essex Primary Care Trust
West Essex community provider
The Princess Alexandra Hospitals NHS Trust
Colchester Hospital University Foundation Trust
North Essex Partnership NHS Foundation Trust
Mid Essex Hospital Services NHS Trust.
Central Essex Community Service
Essex County Council