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

Date of Inspection	**7 September to 20 September 2010**
Date of final Report	**11 November 2010**
Commissioning PCT	**NHS Surrey**
CQC - Children Services Inspector	**Tina Welford**
Provider Services registered with Care Quality Commission Included:	Surrey Community Health Services, Epsom Hospital; part of Epsom and St Helier Hospitals NHS Trust (RVR50) Surrey & Sussex Healthcare NHS Trust (RTK) The Royal Surrey County Hospital NHS Trust (RA2) Ashford and St Peters Hospitals NHS Trust (RTK) Surrey and Borders Partnership NHS Foundation Trust (RXX) Frimley Park Hospital NHS Foundation Trust (RDU)
CQC Region	South East
CQC Regional Director	Roxy Boyce

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

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

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

The team provided feedback to your local Director of Children's Services and partners 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 . Text in italics within the report identifies areas from the joint report that are specifically relevant to health services and healthcare provision within Surrey.

Surrey County Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's Head of Statutory Inspections and Mental Health Operations, who has overall responsibility for this inspection programme.

The Inspection Process

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

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

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

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

Context:

Commissioning and planning of child health services and primary care are undertaken by NHS Surrey; universal services such as health visiting, school nursing and paediatric therapies are delivered primarily by Surrey Community Health and Central Surrey Health. The latter is a social enterprise funded through NHS funds which provides NHS services. The acute hospitals providing A&E services for children are: Epsom Hospital and Queen Mary's Hospital for Children (parts of Epsom and St Helier University Hospitals NHS Trust), Frimley Park Hospital, Surrey & Sussex Healthcare NHS Trust, The Royal Surrey County Hospital NHS Trust and Ashford and St Peters Hospitals NHS Trust. Children and families access primary care through one of 132 GP practices, walk-in centres including Weybridge and Woking, and the urgent treatment centre at Surrey & Sussex Healthcare NHS Trust. Child and adolescent mental health services (CAMHS) are provided by Surrey and Borders Partnership NHS Foundation Trust under a Section 75 arrangement. The Domiciliary Service in the south-west of the county for children with complex needs is provided jointly with Surrey Council. Maternity services are provided by Surrey and Sussex Healthcare NHS Trust, Epsom Hospital, The Royal Surrey County Hospital NHS Trust Hospitals, Frimley Park Hospital NHS Foundation Trust and Ashford and St Peters Hospitals NHS Trust.

1 General – Leadership and management

1.1 NHS Surrey and Ashford and St Peters Hospitals NHS Trust have recently made a number of new senior appointments including a new Chief Executive at NHS Surrey who commenced during the inspection period. There is a clear shared vision and aspirations to further enhance safeguarding and develop the looked after children services with health providers and across the wider partnership. However, acceptance of the responsibilities of corporate parenting is not mature within the new senior executive teams. All GPs (GPs) and community staff from both Surrey Community Health and Central Surrey Health reported good partnership working within primary care settings at field work level, although some GPs reported not seeing their named GP and school nurses as frequently as they do their health visitors which is limiting the sharing of information.

1.2 Partnership work is of variable quality and needs to be re-enforced at strategic level with all key partners, in particular in strengthening the functioning of Surrey's Safeguarding Children Board. The re-configuration of social work teams has disrupted partnership working at a local level, although there is evidence that this had been sustained at a casework level. There is a broad commitment to co-operative and collaborative working between agencies and some examples of this working well at a local level.

1.3 Surrey Safeguarding Children Board (SSCB) has recently appointed a new independent chair and the recent senior health appointment in NHS Surrey is helping to improve the senior working relationships and engagement.

2 Outcome 1 Involving Users

2.1 User views and experiences, however, are not systematically collected and used to inform service evaluation and improvement, this was particularly evident in health services. Regular participation of some looked after children and care leavers at a strategic level through the Corporate Parenting Board is effective. However a challenge remains how to ensure that the views of the wider looked after children population contribute to strategic planning across the partnership.

2.2 There was no evidence seen during the inspection to indicate involvement of children and young people (CYP) in service planning and delivery. User views were collated by Surrey Community Health with the redesign of and relocation of health visiting services but there was no evidence to show how these views had been used. Similarly, views were gathered as part of the evaluation of 'Monday4U' partnership, (the partnership includes Surrey Community Health, Connexions, Surrey Youth Development Service and Heads Together Counselling Service for Young People) and whilst proposals are included in the report dated August 2010, it is too early to show how these are to be implemented. The report stated that service user views are discussed at team meetings each quarter, but there is no evidence of action taken as a result or how the recommendations made in the 2008/09 report have been fed back to service users.

2.3 The 'You're Welcome' standards have not been introduced within health services; however NHS Surrey is working with a range of services and providers across the county, including the Woking CASH clinic, which is awaiting confirmation of accreditation. There is a training DVD and a workshop for GPs by the Young Person's Participation Group planned for later in the year.

2.4 The latest annual NHS Surrey Safeguarding report referred to the use of the children's council representatives being involved in health staff recruitment but no further data or examples were provided, and staff interviewed were not aware of this taking place.

2.5 All health staff interviewed were aware of how to access the translation and interpretation services but most staff have not needed to access the service. There are a low numbers of people from black and ethnic minority groups and people for whom English is a second language in Surrey; however staff have a range of cultural based information packs available to them. One example was readily available in Ashford and St Peters Hospital A&E department giving staff information on genital mutilation.

2.6 Areas inspected at Ashford and St Peters Hospitals NHS Trust had a range of children and family information leaflets in English freely available.

2.7 Looked after children and young people who leave the care system do not receive a copy of their own health information. There is an inconsistent approach to the providing of birth related information for them which is not in line with the Statutory

Guidance on Promoting the health and well-being of looked after children and does not allow the young person to have a record of the health history which they may require for future employment, life insurance and for their own family health history.

2.8 There was some evidence in the health action plans of involvement of service users but this was not consistent. Specialist nurses reported that they had asked care leavers what health information they would like and it was stated that young people said they did not want their health history, but the reasons behind this were unclear. Staff reported that looked after children and young people were given a copy of the annual health review action plan and this was sufficient for the young person's needs.

3 Outcome 2 Consent

3.1 A&E information systems at Ashford and St Peters flag children and young people known to social care which includes looked after children and young people as well as those adults with consenting rights and responsibilities. This information is clearly available on paper records as well, ensuring that the rights and safety of children and young people are maintained. . This process and the records are audited on a weekly basis so any errors or gaps are addressed in a timely manner. This same approach was reported to be in place throughout the children's services at the hospital in order to standardise and ensure consistently in treatment approaches. Patients and their families and carers are informed that their attendance at the A&E department will be reported to their general practitioner and community nursing staff.

3.2 Closer partnership working and liaison with Child and Adolescent Mental Health services (CAMHS) has ensured that when a patient is treated in Ashford and St Peters Hospital A&E department following an incident of self harming that the patients' wishes are considered and their agreement for information sharing is obtained.

4 Outcome 4 Care and welfare of people who use services

4.1 All health visitors and schools nurses work as part of the 0-19 team. These teams ensure that the most appropriate professional continues to work with a child, young person and their family or carers. Health visitors interviewed include within their caseloads schools located within their geographical base, using the traditional school nursing service model, and school nurses may have babies and under 5 year olds within their caseloads. There are dedicated staff that work within special schools and ensure that health, school statement reviews and in some cases looked after children health reviews are all undertaken at the same time to maximise the sharing of information and reduce the stress for the young person. The looked after children (LAC) Specialist Nurses may undertake some of the more complex health assessment reviews, and provide advice and support to the community health staff. This approach works effectively and is preferred by non health staff as it provides a comprehensive approach to sharing of information. The co-location of community children nurses within the 0-19 teams has enabled joint discussions, monitoring of the A&E attendance notifications, sharing of hidden harm concerns as well as cross boundary working with children of school age. This new model of working is starting to have a

positive impact on working practices and therefore children and families by improving the sharing of safeguarding information and intelligence on vulnerable families. Some GPs who took part in interviews were not clear as to the role and function of the 0-19 teams, and therefore were unclear on whom to refer children and families to.

4.5 The social care eligibility criteria are now clear and appropriate but more work is required to promote more consistent application of these and partners' understanding of this. Senior managers within the service have identified and acknowledged this.

4.6 Clear case transfer protocols between assessment and long term teams usually enable cases to transfer promptly and at an appropriate time. However capacity within the child protection and court proceeding teams to respond in a timely manner to transfers is beginning to be strained.

4.7 Substance misuse services reported differing experiences of referring thresholds depending on who is receiving the referral. This is improving with the social worker based in the 'Catch 22' service who is helping to clarify and ensure that the concerns and risks are clearly identified in the referral so that it meets the thresholds, and the young person will qualify for an assessment.

4.8 Acute and maternity hospital staff report that since the removal of the hospital social worker/link social worker role, there has been a reduction in social care representation at the weekly trust safeguarding forums that are used to discuss children and young people that are a cause for concern. Health staff report that there are now inconsistencies in the reporting of the progress of referrals that often result in re-referral of the same children or young persons. This issue has been escalated to senior managers and chief executives of health trusts and Surrey County Council. The health providers' named midwives, named nurses and the community liaison staff attempt to follow up cases and report back to the referrer and ensure that no child or young person is left in an unsafe situation. Midwives and maternity managers reported incidents involving newborn babies, who are known to be at risk and vulnerable pre- birth, that can remain in hospital for up to six weeks, when medically fit for discharge, because there was no birth plan in place prior to delivery and no arrangements have been made by social workers for their discharge. Often this delay in discharge is due to social workers seeking legal advice. Discharge delays can increase risks for the new born baby of developing infections and suffering attachment and emotional developmental delay.

4.9 Annual health assessments for looked after children and young people are inadequate with only 3 files (two of which were extra files selected by NHS Surrey through Surrey Community Health and were recent cases) having evidence of an annual health assessment taking place. There was no evidence of follow up of the action plans, and in one file a young person was still awaiting a CAMHS referral after 3 years. LAC health staff reported being confused as to whose responsibility it is to monitor the implementation of the health action plan. There is no evidence in the files that the Strengths and Difficulties Questionnaires (SDQ) are being used as part of the health assessments although they are used by the CAMHS provided by Surrey and

Borders Partnership NHS Foundation Trust to measure the impact of their services/treatments in improving the emotional, and mental health well being of CYP. The outcomes, to date, show that there is an improvement in the emotional well being and mood in most cases. The health case file review findings are in line with the same issues identified by a recent audit by NHS Surrey in August 2010.

4.10 As a result of the introduction of a dedicated looked after service in June 2010 there is no waiting list for a looked after child to access CAMHS. Referrals are managed through the CAMHS looked after children services which holds weekly meetings to review the risks and needs of LAC and monitor staff workload and prioritise cases. The eating disorders services offers a needs led therapeutic contact approach, and has no waiting list with all referrals seen within two weeks. This ensures young people and their carers are supported quickly and often at a time of crisis; this support continues throughout the three year programme of treatment. The increasing number of referrals to the service and the intensive support given may not however be sustainable with the current capacity levels.

4.11 Cumulative targets for health and dental checks for LAC were met in September 2009 (85.3%) and again in March 2010 (85.2%). Staff reported that this was due to a period of increased activity just before the end of the reporting period and this activity was not organised in a consistent manner throughout the year. This is supported by the data which shows that this rate is not sustained and that the service is not meeting its own locally agreed targets. The percentage of looked after children and young people receiving health and dental checks has dropped from 57.2% (health checks) and 70.2% (dental checks) in July 2009 (cohort of 577 children) to 15.1%(health checks) and 10% (dental checks) in July 2010 (cohort of 598)..

4.12 There is no dedicated LAC dental service on the principle of ensuring normalisation. Although there was no data or monitoring to measure the impact this lack of specialist provision was having on children and young people accessing dental services the rates of dental checks remains low. Immunisation rates for LAC are inconsistent, showing a decline over the last 5 years, from 82.1% 2005/06 to 65% in 2007/08 with an improvement in 2008/09 to 76.8%. However, this rate dropped again in 2009/10 to 74.7%. Members of the looked after children health team, believe the decline is due to the increase in the number of looked after children (at the time of the inspection there were 764 looked after children) and lack of capacity within the team to deliver the service, however this is unqualified and no formal health review of the decline in rates and failure to reach health assessment targets has been undertaken.

4.13 Rates of teenage conception and pregnancy are below England averages and in line or below with statistical neighbour averages; however this data masks some ‘hotspot’ areas within the county. In these areas there are a number of dedicated projects and the 0-19 team reconfiguration has taken into account the need to increase staff capacity in these areas. However, as yet it is too early to demonstrate the impact of these initiatives. The Monday 4u and ‘clinic in a box’ review shows that the existing provision for the school population is variable and is found not to meet the needs of the users in rural areas. Plans have been agreed with education managers to extend the services, but this revised pilot service is not due to commence until November 2010.

4.14 Changes within the teenage pregnancy service have reduced the number of dedicated midwives for teenage pregnancy. As a consequence some midwives have developed a specialist interest in teenage pregnancy as part of their normal caseload. Where there is a dedicated teenage pregnancy midwife there is an increase in the engagement of both young women and fathers with the service and improved attendance at clinic. Where there is a reluctance to attend clinics the midwife, health visitor and Connexions PAs are able to develop individualised care packages, ensuring that the mother to be, her baby and the father are provided with a service which meets their needs and reduces risk and vulnerabilities. Ashford and St Peters maternity services refer all pregnant under 15s to social services.

4.15 Within the recent weeks the level of engagement and communication with social care is reported to have improved, although there still a concern regarding the thresholds for substance misusing young women which are felt to be too high. Escalation policies are fully embedded and well used to ensure that young women and babies remain safe. There are good professional meetings held weekly to discuss cases of concern which involve both the maternity, children services, A&E staff and community staff as appropriate, plans of action are then agreed, implemented and monitored to ensure that the concerns are fully addressed.

4.16 The abortion rate is high with over 59% of conceptions resulting in a termination, health staff report that this is due to the ease of access to the services, but also as an affluent area parents pay for private terminations. Health staff may not be aware of the young women who had had a private termination and the need to provide post termination contraceptive support. There was very limited dedicated work with looked after young people promoting sexual health, assumptions had been made that young people would access the sessions held in school or the after school clinics, but audit data shows this was not always the case.

4.17 The annual report for the Surrey Community Health Teenage Pregnancy Outreach service for 2009 shows that within one of the areas with high rates of teenage conception and pregnancy that only three LAC accessed the service and overall the rates of access were thought to be low. There was no reason stated for this, similarly the service had not obtained the views or perceptions of service users. The team in Spelthorne have, however, in the last twelve months, established effective working arrangements with the local office of National Association for the Care and Resettlement of Offenders (NACRO) which has resulted in additional sexual health sessions being provided.

4.18 The specialist nurses for Looked after Children in Central Surrey Health provide parenting and health skills training supported with connexions and Catch 22 for those young women returning to education post birth of their child, however the reduction in funding from the area based grant is requiring a service reconfiguration, and staff are concerned that this will affect the quality and number of services provided.

4.19 Anecdotally staff reported that the service had stopped a number of young girls becoming pregnant again. The service report for September 2010 outlined that the service had enabled up to 15 young women in each of the four areas to return to employment, education or training.

4.20 CAMHS is provided by Surrey and Borders Partnership NHS Foundation Trust. The LAC pathway has recently been reviewed and commenced in May 2010, however there has been no monitoring to show how this is impacting on the access, care and treatment of young people. The strengths and difficulties questionnaire (SDQ) are used as part of the referrals and assessment processes, and are completed by both the foster carers and teachers as well as the young person if they are capable of doing so. These are triangulated and are repeated at the end of treatment as part of the measure of effectiveness but the collation of results is inconsistent . Since this process has been introduced it has increased the joint working with other agencies, and the CAMH service has recently commenced training for foster carers and offers a number of support groups on coping strategies and the emotional well being needs of looked after children and young people. Foster carers reported that these were highly valued. This work is now provided in partnership with the social care placement stability team and is starting to improve placement stability by working in a proactive rather than a reactive manner.

4.21 Tier one CAMH services are provided through universal services to support front line staff and one school nurse for each area of the county has been identified to develop a special interest in CAMHS and they have received additional training. These staff work along with the Primary Mental Health Workers in schools jointly with the young person and teacher. This approach to treatment and care delivery has not been monitored to show how it is making a difference to the emotional well being of the young person.

4.22 Sex and relationship education is provided in a range of formats, the RAISE youth team who work with vulnerable young people and those who are looked after, have disabilities and young parents, are promoting personal and social development information sessions in a targeted way. This has increased the skills of young people to look after their own lives and their child development and therefore has preventing some young people becoming more vulnerable or into care system. The project is also working with foster carers and is improving their skills in order that they can discuss sexual and personal relationships with young people. However, there is no formal evaluation of the impact this is having on reducing teenage pregnancies. Individual case studies were presented through the use of a Facebook site, where youth workers are able to contact the young person, give advice to keep them safe and signpost them to sexual health services.

4.23 School nurses and health visitors in the 0-19 teams hold after school drop- in sessions and provide on going sexual health advice and education in schools. The 0-19 teams reported receiving notifications from the local police force of young people who have been seen displaying risk taking behaviours which they follow up in school, but staff reported that due to staffing pressures their involvement has been reduced, and they do not always have the capacity to follow up reports. Staff are unaware if education staff or social care staff follow up reports. This has the potential to leave the young person vulnerable or at risk.

4.24 Substance misuse services are using the common assessment framework (CAF) and work with education services (as a result of Catch 22) delivering substance misuse education in schools and increasing the awareness of teachers. They have produced a range of information/training packs for educational and health staff as a

result in the increase use of ‘legal highs’ in three schools, which have improved staff knowledge and have increased the number of referrals and signposting of young people to access services. Catch 22 staff reported that young people are unhappy with the CAF process as they feel that their needs and the fact they are abusing substances, should be confidential. They believe that the Catch 22 service is confidential, and the CAF is ‘too public’ and as such if a CAF is initiated the young person can fail to engage with services.

4.25 There are well established links with mental health services through the ‘no barriers’ project which is starting to show good individual results. Services have reported a drop in referrals during school holidays but there is no formal evidence to show that the preventative strategies are reducing substance misuse at ke times of the year.

5 Outcome 6 Co-operating with others

5.1 There is good health contribution to case conferences and strategy meetings, either in person or by submission of reports, although health staff reported that the notice period was not long enough for most meetings and they are not given enough time to prepare reports or to rearrange their clinical work.

5.2 Community based staff reported that if they are not able to attend meetings that communication of actions and outcomes from meetings is slow and in some cases they have not been informed that there was a meeting, the outcome of the meeting and therefore the required actions are not completed. Named professionals contribute directly or support other health professions when producing reports for child protection meetings and have, with the designated doctor, provided training on serious case reviews and independent management report writing, which has improved the quality of the reports.

5.3 Annual safeguarding and LAC reports have been appropriately presented to NHS boards but content is not in line with the Working Together Guidance and there is no evidence to show that all reports have been presented to the SSCB to ensure appropriate monitoring takes place.

5.4 Health staff working within unscheduled care services stated that the eight page initial common assessment form (CAF) which has to be completed is too long and time consuming and that they do not have the capacity to complete it within busy clinical settings. There is an increased reliance on the single referral form to access social care services, and despite the recent relaunch of CAF, and all staff receiving training, few reported seeing any benefit from the process on improving the outcomes for children and young people. In the North-West the CAF form would, though, be completed when a referral into the child development centre was needed as this is the only method of referral into the service.

5.5 Proactive CAMHS support is now provided in partnership with the social care placement stability team and is starting to improve outcomes. Two Primary Mental Health Workers work with young people up to the age of 25 years from ‘hard to reach’ groups; their specific remit is to work with non statutory groups and therefore to facilitate this have based themselves in the YMCA. They work effectively and provide

well received training alongside Catch 22 -24/7, Surrey Young Peoples Drug and Alcohol Support Service, the 18 years plus Looked After Young People Team, Connexions and with those young people not in education, employment or training. The Primary Mental Health Workers provide self harm and anger management workshops, as well as working with individuals who are self harming. The service is designed to provide a flexible response, for example when there had been an increase in the number of young people self harming in one school, providing training to teachers and educational staff and working with the young people. The service monitors outcomes formally on a quarterly basis, measuring reduction in self harming thoughts and improvement in the young person's mood, but results on overall service impact were not available.

5.6 The establishment of the multi agency steering group for disabilities services, and pooled budget arrangements has improved the willingness of services to work together. As a result, services are starting to view the provision of services to children and families in a more holistic manner; however this is not the same across all partners.

5.7 Surrey LAC who are placed out of the authority area have their requests for their annual health assessment made by the social worker team. Monitoring is done by the acting designated LAC nurse, via the social care electronic tracker system. There have recently been delays and challenges in getting the assessments completed, due to the provider organisations in the other authorities requesting payment before undertaking the review. This has been subject to a regional review by the local Strategic Health Authority but was awaiting resolution.

5.8 The small dedicated LAC nursing team monitors the healthcare of children placed in Surrey from other authorities in the large number of independent and private children's homes. They try to link with the young person's social worker, however staff reported that they often have difficulty identifying or locating them inhibiting the flow of contemporaneous information and delaying treatment especially for mental health service. This results in diversion of resources from Surrey Children and young people as the specialist nurse is undertaking administration functions rather than providing direct care

5.9 The dedicated social worker based within the CAMHS team is seen as strength by staff and has improved the quality and acceptance of referrals to social care, including child in need referrals and liaison with family support workers. Staff reported that since the individual has been in post there have been fewer rejected and closed referrals, reducing administrative pressure on staff making repeats referrals.

5.10 CAMHS works jointly with the adult mental health services to plan transition for young people from six months before they turn 18 and monitors progress through to adult services. This way of working is viewed positively and works well with a dedicated care coordinator ensuring that services are accessed and that where there is no comparable adult service the patient is signposted to other services to ensure there is no gap in provision. The co-location of the adult and CAMHS services has now ensured that services working with individual family members are coordinated effectively with good sharing of information, following the 'think family' philosophy.

5.11 Thresholds for referral to social care services were not fully understood and in some cases health staff reported these being too high with a number of cases being closed before an initial assessment had been undertaken and without informing health staff. This was discovered when health staff contacted social care teams to ascertain how the case was progressing, to be informed that the case was closed and that they were the named lead professional for the ongoing monitoring of the case. A number of examples were provided which showed that when successfully escalated or re-referred the case was accepted by social care teams and the child or young person was subject to legal proceedings or had been taken into care. The designated doctor reviews all the 'rejected' or closed cases and supports practitioners when making a re-referral to ensure that the child or young person remains safe

5.12 Community health staff and family link coordinators all reported that referral thresholds are unclear and do not define easily who is responsible for the care of CYP with complex needs where there may be a range of concerns, including physical and learning disabilities and difficulties. Neglect related to an ongoing or long term medical condition was not always fully understood by the social care initial assessment and contact teams resulting in referrals often not being accepted causing delays in protecting the individuals involved. Staff are confused as to who is the case worker - staff from the children with disabilities team or social care staff resulting in delays in treatment and services, and situations becoming more difficult to navigate for families. A meeting is due to be held after the inspection period with the council Chief Executive and health provider Chief Executives to review the situation and agree a more effective way of working

5.13 Parents of disabled children and those with complex needs report that there is no directory of services and social care staff do not know what is available, with inconsistent or inaccurate information being received. This confusion is adding to the frustrations felt by parents over the lack of awareness of their needs and support to keep their children at home rather than in care.

5.14 A&E staff at Ashford and St Peters have a good working relationship with the local police force when patients are admitted as a result of domestic violence and identify if there are any children in the home. If children are known to be in the home, A&E staff, both in the dedicated children's department and adult services, will make a referral to social care and inform the trust named nurse for safeguarding children and liaison health visitor to ensure that this information is communicated to the community and primary care staff. .

6 Outcome 7 Safeguarding

6.1 Health staff reported that the level of challenge at the Surrey Safeguarding Children Board (SSCB) was not constructive or robust and that the lack of senior membership and the size of membership are restrictive, preventing debate and discussion. The recent reconstitution of SSCB and appointment of an independent chair has resulted in a change of health representatives and some staff feel that as a result communication has been affected, with several groups of staff reporting that they see no minutes or communication from the SSCB.

6.2 The SSCB health sub group was seen to be productive with constructive

challenge and discussion of issues and is just starting pursue accountability for action plan implementation. The effectiveness of this group has yet to be measured due to the recent reconstitution of its membership.

6.3 GPs interviewed during the inspection were unable to identify the named GP. If safeguarding concerns were identified GPs stated they would perhaps discuss these with colleagues or contact social care, to ensure the child was safe. However this was not systematic and was based on an individual's approach rather than an embedded procedure.

6.4 The recent increase in capacity of Designated Doctor and the Named Doctor for safeguarding with clearer demarcation of the commissioner and provider split in place has improved effectiveness. However the safeguarding lead professionals reported that there remains poor engagement of GPs with safeguarding and looked after children and young people's services

6.5 There is named health professional safeguarding children supervision group in place, however due to increased workloads being experienced by some of the members the group, they have not been able to meet. However all named professionals have access to one to one supervision which is ensuring that their practice is reviewed and developments supported.

6.6 All health staff, excluding GPs, reported having electronic access to current safeguarding policies and procedures, any changes to these documents are identified in the annual update training and through email alerts. Updated policies are sent to GPs, who reported that the volume of emails they receive prevents them from opening them all resulting in these often being missed.

6.7 A number of safeguarding policies have been reviewed within the last three months, and include clear flow charts for both 'in hours' and 'out of hours' referral pathways and contact numbers. The NHS Surrey safeguarding policy includes a section on animal abuse and the link to child abuse, for which joint training with the Royal Society Protection of Animals (RSPCA) has taken place. Staff reported referring incidents of alleged animal abuse to RSPCA inspectors; however they were not aware of any referrals from the RSPCA of animal abuse in homes where children and young people live, and feel that the training has not had the impact that was anticipated

6.8 There are also a number of action plans from previous serious case reviews and individual management reviews which are not being fully implemented and embedded due to lack of capacity within the team and therefore improvements to practice are being delayed.

6.9 The Named Doctor is also the Named Doctor on the Child Death Overview Panel (CDOP) which ensures that lessons and information can be shared in a timely and prompt manner and that actions required to safeguarding children and young people in Surrey, or changes in policies and procedures, can be undertaken quickly.

6.10 The child death overview panel (CDOP) is well established, with good engagement from all partners. However there is approximately only a 50% attendance by GPs at panel meetings. The CDOP Chair had only been in post for 4 months, and

therefore the role of the Chair in leading the CDOP cannot be evaluated as there had only been one meeting held. Members reported that although the panel had been slow to establish, the rapid response team was now in place and service responsiveness had improved. The panel deals with approximately 40 deaths per year; a majority of these deaths were expected, the rest were classed as preventable including road traffic accidents.

6.11 The rapid response team is well established, with a dedicated specialist nurse supporting parents well along with primary care staff and making initial contact with parents within 24 hours of the death. This facilitates good communications between parents and the CDOP. Surrey Safeguarding Children Board (SSCB) receives the CDOP annual report for information only, there is no pattern or trend monitoring of deaths as CDOP feel that they have not had enough deaths to make any judgements.

6.12 There have been a number of changes to policy and practice as a result of child deaths for example the change in the pathway for triage with out of hours doctor services, which has now been adopted nationally. Other examples include work with housing and the appropriateness of placements for families with young babies and the need to have thermostatically controlled heating systems in place, as a result of a sudden infant death. Parental awareness of the CDOP has increased with requests for copies of meeting minutes and information. The CDOP coordinator receives notifications following all child deaths, but some providers over geographical boundaries may not notify the panel of a Surrey child death in their area, which causes delays in the post death review. There remains some confusion with neighbouring authorities with regard to the notification and which panel should review the death of an out of area looked after child or young person placed in Surrey.

6.13 There are concerns that there is insufficient protected time for the countywide named GP role, due to the size of the county and the volume of outstanding work, such as training. Prior to the appointment a number of named GP posts were vacant for at least twelve months resulting in a lack of comprehensive support and advice to primary care. Some GPs had contacted the designated and named doctors for advice but this was not consistent. Designated professionals stated that safeguarding requirements are not covered in GP contracts and therefore they are not empowered to take action; however they have been encouraging the use of appraisals to increase awareness. Quality outcome measures for GP supervision and appraisals are yet to be developed and implemented.

6.14 The A&E information system at Ashford and St Peters has a dedicated link to the ‘live’ social care system which has improved access for staff to the ‘at risk register’. There is good access to the social care out of hours teams but there have been some occasions when a register check has been requested, and the member of social care duty staff has taken this to mean that A&E staff have made a referral.

6.15 A new sexual assessment and referral centre (SARC) service is due to open in January 2011. The sexual abuse procedures have been reviewed but are yet to be distributed. Due to the current service configuration and provision those medical practitioners trained in sexual examinations are not able to maintain their skills and competencies due to the low number of referrals, the revised process aims to rectify this and improve the quality of the examinations and reporting. The new system will

operate a single point of access, which is currently not the case, as currently children and young people who may have experienced abuse may either be examined in A&E if relevant professionals are available, or be directly transferred to a neighbouring authority for the physical and/or forensic examinations, contributing emotional stress and anxiety for the young person. Staff feel unable to alleviate this additional stress and consider that they are not providing as good a service to the young person as they need.

6.16 Health and social care staff involved in child protection medical examinations held differing expectations of each others' services and, as a result, new guidance has been introduced which has clarified the role of the services, for example ensuring that children and young people attending the examinations have an appropriate person who is able to give consent. All referrals are seen within 24 hours and reports are written within 3 working days in over 80% of cases. All alleged sexual abuse medical examinations take place within 2 hours of the request being made. This service is currently being audited to ascertain the overall effectiveness.

6.17 There is good use of a Facebook page used to impart information to young people with regard to sexual health services, safe sexual health practices and substance misuse. Young people are using this forum to communicate with youth workers and to evaluate the services provided. Feedback from young people showed that they are using the site well and value the access it gives on an informal basis to professionals.

6.18 CAMHS has access to two dedicated NHS beds with other two private beds available through the Hope service. There are often delays in obtaining tier 4 beds and therefore another bed (often from the London hospitals), is identified in order to ensure safe and prompt treatment. The Hope service mandate is to stop out of area placements; however this is not always successful and there is no link to the children in care team to work in partnership. Hope staff will visit a young person placed out of area until a suitable other bed can be found and the service is highly valued by CAMHS staff and service users in keeping young people safe.

6.19 The early intervention psychosis service works well with partners at Ashford and St Peters Hospital, through transition pathways (including to adult mental health services), in-reach workers for the local prison and the community mental health teams, who are providing a dedicated service for those judged to be high risk cases, and have produced a three year plan of care. The impact of this service has been to reduce the number of referrals to CAMHS, and prevent crisis admissions, with some identification of improvements in the outcomes for the young people and reduction of dependency on adult mental health services. However it is too early for individual measures to be qualified.

7 Outcome 11 Safety, availability and suitability of equipment

7.1 Ashford and St Peters A&E department has a dedicated children's service including triage, minor and major injuries areas and dedicated resuscitation facilities. The hospital has the Surrey level 3 neonatal service and there is a good working relationship with a number of retrieval teams for fast access and transfer.

7.2 Parents of children with disabilities all reported having good access to equipment, however some parents reported that there is no planned preventative maintenance programmes and as a result equipment repairs were needed more frequently. The repair service was seen to be responsive and equipment was quickly back in use unless, for example, it was over a bank holiday weekend. Some parents reported that Occupational Therapy Service assessments resulted in equipment need being identified but not always provided There was also a gap in provision of equipment for young adults, especially if the young person was the same size as an adult. Children services do not have access to adult sized equipment. Some families reported that adult services treating adolescents did not appreciate the needs of a young person.

8 Outcome 12 Staffing recruitment

8.1 Following the joint area review in 2008 and concerns raised through section 11 audits all managers now undertake safer recruitment training and all staff reported having a CRB check prior to taking up post. .

9 Outcome 13 Staffing numbers

9.1 Staff within Central Surrey Health reported that there was a recruitment freeze, and this was affecting the capacity within the teams. The skill mix review of health visitors and nursery nurses had been undertaken; whilst there were plans to employ administration staff to release qualified staff to spend more time on direct care this had not been implemented.

9.2 Surrey Community Health has increased the number of commissions for health visiting training and as a result have filled their health visiting establishment. However retention remains a concern as staff move to the neighbouring London boroughs which are able to offer higher pay rates. Senior managers are aware of this and closely monitored the retention rates.

10 Outcome 14 Staffing support

10.1 All health staff interviewed stated that there is good access to SSCB level 3 multi agency training, with the exception of general practice staff.

10.2 Engagement and training of GPs in safeguarding is weak.

10.3 Evidence of LAC case supervision with the acting designated nurse for LAC is now taking place with copies of supervision records filed in the health notes. It was not possible to track the implementation of actions recorded in the supervision notes.

10.4 All Ashford and St Peters A&E staff (including medical staff on rotation) are up to date with their safeguarding training as well as trained in pain assessment and life support skills appropriate to their role and grade.

10.5 Training data shows that there is adequate to good attendance but there is no comparison of the number of staff trained against the expected number to be trained.

All groups of training are in line with statutory guidance but no formal evaluation of the impact of training on service delivery and practice has been undertaken.

10.6 GPs training is inconsistent with some reporting 15 years since they received safeguarding training. There are plans in place to develop further the safeguarding agenda within general practices and a SCR had identified this as an area for action. A new Named GP was appointed in April 2010 for NHS Surrey who is developing a county wide approach to the implementation of safeguarding training which is due to commence in Spring 2011. This post is a member of SSCB, which is helping to improve communication and there are plans in place to develop safeguarding champions within a defined GP clusters.

10.7 The e- learning level 1 safeguarding module is used with the out of hours contracted primary care doctor service, however the number of staff trained and how this has affected practice has not been monitored.

10.8 Two general practice staff interviewed during the inspection reported that they hold regular primary care case review meetings when cases of concern, current cases proceeding through the child protection system and attendance at A&E departments are discussed and action agreed allocated and reviewed. Health visitors reported being invited to attend these meetings.

10.9 Supervision for those staff involved with looked after children has recently improved since the secondment of the Deputy to the Designated Consultant Nurse Safeguarding to the designated LAC nurse post, which is yet to be made substantive. Field work staff rated highly the supervision and support that this individual was now offering them.

10.10 There is no Designated Doctor for looked after children, the business case for this role had just been funded at the time of the inspection and the recruitment process was to commence after the inspection. The delay in establishing this role has caused a lack of strategic leadership and capacity within the service.

10.11 The medical advisor based in Surrey Community Health works within the adoption and permanence service advising adoption and fostering panels of the medical suitability of new adoptive and foster parents and undertakes the adoption medical of children and young people, for in authority and out of authority places. Additional administrative support has been identified to improve the effectiveness and quality of interaction and engagement with families and improve the support to birth parents in the adoption process.

11 Outcome 16 Audit and monitoring

11.1 Community Health providers have supported the audit methodology used within the council, that of ‘deep dives’ that are used to interrogate specific areas of performance and identify and drive service improvements. However this approach is not fully embedded as there is no robust feedback mechanism in place. There is no effective monitoring of the LAC outcomes, although performance reports are produced quarterly. These reports are rated either red or amber as a risk of non compliance

with the targets but there is no evidence to show what action is taken to mitigate these risks.

11.2 Section 11 audits show a number of areas rated as 'red' requiring high priority action, or have failed to meet the target. There was no evidence that the SSCB has reviewed these, for example in some audits actions seen from Surrey and Borders Partnership NHS Foundation Trust, showed that there were still a number of outstanding areas from previous years audits, there was no evidence to show that these have been monitored, or lead managers had been held to account over this failure to achieve the actions planned.

11.3 The acting Designated LAC nurse is making good use of the social care tracker to monitor the progress of health assessment; however it is not linked to the performance monitoring within the rest of the health organisations.

12 Outcome 20 Notification of other incidents

12.1 All staff interviewed were aware of their organisations 'Whistle Blowing' policy although had not needed to use it.

13 Outcome 21 Records

13.1 Health records seen during the inspection complied with NMC and other professional body guidance. Files seen from Surrey Community health contained good chronologies, with evidence of safeguarding actions being followed up. This was not the case in all the files seen, even though some were active and completed during the same time period. Some of the files seen contain evidence of supervision, although it was not always clear what action was being taking to the points recorded in the supervision record.

Recommendations (those from the joint report are italicised)

Immediately

(Joint) NHS Surrey and Surrey Community Health should ensure the prompt recruitment of a designated doctor for looked after children and that the post of designated nurse for looked after children is made substantive.

Within 3 months

(Joint) The designated safeguarding children doctor and nurse should ensure that the partnership working between acute and maternity healthcare providers and social care safeguarding contact and referral services enables safeguarding concerns to be identified and referrals made promptly in order to protect and maintain the safety of children and young people.

(Joint) Surrey Community Health, Central Surrey Health and NHS Surrey must ensure that all looked after children and young people who are leaving care receive a copy of

the health history and have continuing access to health advice, which is included in their pathway plans.

Within 6 months

(Joint) All Health providers must develop consistent methods to monitor an audit the impact, quality and effectiveness of individual and multi-agency work.

(Joint) Central Surrey Health, Surrey Community Health and NHS Surrey should ensure that the number of completed annual health assessments for looked after children and young people and subsequent monitoring of action plans are improved in line with national and statistical neighbour averages. .

(Joint) The Surrey Safeguarding Children Board should ensure that all GPs are aware of their safeguarding responsibilities and that they are represented on and actively engaged in safeguarding.

Next steps

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