

Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Kent – NHS Eastern and Coastal Kent PCT and providers.

Date of Inspection	11-22nd October 2010
Date of final Report	19th November 2010
Commissioning PCT	NHS Eastern and Coastal Kent (5QA)
CQC Inspector name	Lynne Lord
Provider Services Included:	Eastern Kent Community NHS Trust (RYY) (from 1 November known as Eastern and Coastal Kent Community Health NHS Trust) East Kent Hospitals University NHS Foundation Trust (RVV)
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 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.](#)

Kent County Council	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Inadequate
Capacity for improvement	Inadequate
Looked After children Inspection Outcome	Aggregated

	inspection finding
Overall effectiveness of services for looked after children and young people	Inadequate
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 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 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:

Health services for children and young people in Kent are commissioned by two primary care trusts (PCTs) NHS West Kent and for the East of the county by NHS Eastern and Coastal Kent. Within East Kent, the majority of community services are now provided by Eastern and Coastal Kent Community Services, with some services provided by East Kent Hospitals University NHS Foundation Trust. As named at the time of inspection, within this report, the community trust will be reported as Eastern Kent Community NHS Trust. Acute hospital services including maternity and accident and emergency care are provided East Kent Hospitals University NHS Foundation Trust who also provide Child and Adolescent Mental Health Services (CAMHS).

1 General – leadership and management

1.1 The council and its partners have been ineffective in ensuring that quality assurance and performance management arrangements are used to ensure that children are appropriately safeguarded or to effect improvements in policies and systems to support improved practice. Despite a wealth of performance information from audits, the impact of performance management in ensuring improved management and practice as well as compliance with policies, procedures and guidance is limited

1.2 There is a clear strategic vision across all healthcare groups within NHS Eastern and Coastal Kent (PCT) (5QA) and the provider services, East Kent Hospitals University NHS Foundation Trust (RVV) and Eastern Kent Community NHS Trust (RYY). This sufficiently details the arrangements for safeguarding children and is supported by appropriate policy and procedure guidance.

1.3 There is an established assurance framework and staff have identified responsibilities within this. There is some evidence of good performance monitoring, however despite data from audits, the impact of performance management in ensuring improved outcomes for children and young people (CYP) is limited.

1.4 East Kent Hospitals University NHS Foundation Trust operates at five hospital sites located in Dover, Folkestone, Kent, Canterbury and Ashford. All sites share the same policies and procedures for safeguarding children and all staff receive safeguarding training appropriate to their role

1.5 Health provision for LAC is insufficiently prioritised and whilst front line services are of good quality, children receive an inequitable service across Kent. Statutory responsibilities such as annual reporting on the health of LAC are not complete, the quality of health assessments is variable and despite recent management initiatives there remains a lack of information and strategic planning for improving the health of children who are looked after in Kent.

1.6 A recent service reconfiguration review has been completed and will result in the implementation in January 2011 of an Integrated LAC Support Service. The service will be divided into two teams. One team will have responsibility for LAC from Kent Local Authority (LA) and the other for LAC placed from out of the LA. The line management responsibility has been transferred to the Safeguarding Liaison Team Leader. The team will be colocated and multidisciplinary and it is envisaged, will have improved access to a central data base of LAC across East Kent. It is reported that this will implement a charge for health reviews for LAC from out of LA, which will be direct funding back into each locality where the child or young person (CYP) is placed.

1.7 The profile of Kent's looked after children reveals that more than half have birth families where substance misuse is prevalent. However young people are not routinely screened and there is an acceptance that the 3% or 30 young people (compared to 5% nationally) who have been identified with a substance misuse problem of their own, reflects significant under-detection. There is no clarity about whether the newly launched 'Hidden Harm' strategy targeted at substance misusing parents will be developed or adapted to the needs of looked after children and young people.

1.8 There is little evidence amongst teams of the overall Kent strategy for safeguarding and involvement in development of the Children's and Young People Plan (CYPP), although there is high awareness of the need for safeguarding training and supervision, with the latter process being implemented effectively across all partners. Performance reports against the health priorities within the CYPP are undertaken by the children's commissioning team and action plans implemented as required

2 Outcome 1 Involving Users

2.1 User involvement with health services is variable.

User views have been gained within the Eastern Kent Community Services about the experiences of carers, young children and older children within the LAC service. This is part of the trusts' patient experience survey annual programme. Separate questionnaires were designed for specific age groups of CYP. A comprehensive report completed very recently, identifies recommendations which will be taken forward by the Head of Service and LAC team.

2.2 Practitioners working with asylum seeking children, children with disabilities and the Romany communities demonstrate clear commitment to effective communication using trained professional interpreters.

2.3 Extensive work has been undertaken with the Roma community across Kent but in particularly through the Asylum Seeker health service in East Kent, provided by the designated GP. Although generally engagement is reported to be good, overall it was felt that "cultural competency" is still lacking across health professionals. The

Acute Trust has a new policy in place and have introduced the Big Word interpreting service.

2.4 The Drug and Alcohol team is developing two forums across Kent comprising of current or recent service users, however it is too early to report on any impact from this development. Young people already participate in the recruitment process for senior staff, and are involved in service planning and commenting on development work.

2.5 Across community health teams there are a number of initiatives to enable access to mainstream services by minority communities although there is still under representation within mental health services for parents/carers and children.

2.6 The views of Parents and Carers are routinely taken following each short break for children with disabilities at Windchimes – a centre for Disabled Children in Herne Bay.

2.7 LAC nurses are also involved in training courses for foster carers covering key health and wellbeing issues for CYP.

2.8 The sexual health outreach team also demonstrated that YP feedback influenced the change of venue for a number of drop in sessions in various locations across east Kent and this did result in an increased and sustained attendance.

3 Consent

3.1 There is appropriate policy and procedure guidance in place for staff, in regard to obtaining parental or carer consent for treatment and procedures prior to any treatment or procedure for CYP. This reflects DOH guidance and takes into consideration Gillick Competency of the YP.

4 Outcome 4 Care and welfare of people who use services

4.1 Initial health assessments for looked after children from Kent are carried out by dedicated doctors. Children placed from other authorities receive their initial health assessment from a local GP and there is limited monitoring of the quality of these assessments. In addition, delays in the notification process and pressure on medical staff meant that a significant (but unrecorded) number of children failed to have a health assessment within four weeks of becoming looked after. Only 78% of looked after children had assessments in the last year which is below comparator authorities (82.4%) and England averages (85.4%).

4.2 Where health assessments are undertaken for unaccompanied asylum seeker children interpreters are available and referrals are reported to have good timely responses. Follow up health reviews are conducted by the looked after children nurses and dental and optical checks are conducted alongside the initial health

assessments. All looked after children are reported by health trusts to have access to a GP. Immunisation rates for LAC exceed comparator PCT's at 93% and England averages and 86% of children have had dental checks in the last year, a figure in line with comparators and England averages. The statutory annual health report in relation to LAC had not been produced at the time of inspection.

4.3 Staff report that access is good for LAC from Kent for dental care, opticians and speech therapy and reviews are up to date but for LAC from out of Kent, there are delays in accessing treatments and delayed referrals. This is due mainly to the fact that the LAC health team are unaware exactly where these children are placed and of the total numbers. Non attendance can be identified for Kent LAC but not for the rest of the CYP.

4.4 There is no evidence of targeted sexual health work to prevent LAC becoming pregnant. It was reported that information is shared between health professional involved with LAC and the sexual health team, but it is unclear of the impact of this. The total number of LAC who become pregnant is not known.

4.5 Significant numbers of LAC (56%) have birth families where substance misuse is prevalent but there is no evidence to suggest any exploration of a correlation between this and substance misuse by children or young people in care. However 3% (30 CYP) were identified with substance misuse problem in 2009 compared with a National rate of 5% and all of the 30 received an intervention compared with 60% nationally

4.6 Health visiting caseloads vary across localities between 250 – 450 children. The service delivery framework for health visiting was reviewed and revised in April 2010. This saw the implementation of a risk assessed approach to determine child and family needs. This offers a universal service or referral to the next level within the core service, with additional packages of care as required. This level results in specific interventions via assessed packages of care ranging from breast feeding support , domestic abuse support, emotional and mental health support and teenage parenting Skill mix teams work well across the PCT.

4.7 Tier 2 Child and Adolescence Talking Service (CATS) consists of a school-based primary mental health worker. A high proportion of self harm is reported in local grammar schools, along with eating disorders. Appointments can take up to 6-8 weeks but often avoid crisis situations due to continued interventions by school nurses. In addition there was evidence of some timely joint intervention work by the Primary Mental Health, CAMHS LAC, and school nurses to improve emotional health and well being of CYP. This is having a positive impact in particularly deprived areas, such as Sheppey, and can involve intensive work with behavioural support given to CYP.

4.8 The CAMHS service at Tier 2 is inadequate, with long waits from 9 to 12 months with uncertainty about thresholds amongst referring practitioners, poor feedback to

referrers on outcomes and insufficient use of the common assessment framework (CAF).

4.9 Tier 4 CAMHS has insufficient inpatient capacity; with providers having delegated authority to make placements when required out of hours. Where emergency admissions are required to an adult ward their CAMHS needs are met and transfer is arranged swiftly

Currently the closest secure adolescent ward is in Surrey but plans are in place for a re-commissioned service including a specialist suite in Staplehurst

4.10 Within East Kent Hospitals University NHS Foundation Trust there are 2 WTE CAMHS LAC Specialist posts in Tier 3 CAMHS only working with LAC. All urgent and emergency cases LAC or non-LAC are seen within 24 hours by Tier 3 CAMHS Teams and the LAC Specialist workers target the highest priority LAC cases for appropriate interventions

4.11 There is uncertainty amongst community staff around the commissioned Tier 3 LAC service for Kent children and those placed by other authorities. A specialist team has been commissioned to support carers and front line staff working with Kent LAC. The service is provided by a discrete team of experienced CAMHS clinicians commissioned from Kent and Medway Partnership, who work with the various individuals working with a child to facilitate improved outcomes. The service currently covers mainly West Kent, Medway and part of East Kent – for the remainder of East Kent services are provided by East Kent Hospitals University NHS FT although there are plans for rollout of the service which offers short waits of less than one month for assessment and commencement of the programme

4.12 Transition from child to adult mental health services is poor. CAMHS services are not commissioned for CYP between 16 and 18 although some are retained/taken on early by the service to meet clinical need which impinges still further in the high caseload. Concerns have also been raised about the number of YP who are found under influence of alcohol or drugs, who are deemed to be 16-18 yrs. These YP (around 100 a year) are taken to police cells seen as a “safe haven” as there is no healthcare provision available for this age group. Consequently CAMHS assessments are undertaken in this environment and often these YP are, the next day, found to be under 16yrs

4.13 Teenage conception rates are falling gradually in Kent, at 36.7 per 1000 in 2008 and estimated 36.0 in 2009, but this was insufficient to meet the national target by June 2010. Just under half of conceptions result in terminations (16.9 per 1000 in 2008) and around 10% of those conducted by the main provider in the Kent area (Marie Stopes) were subsequent to a previous termination. The teenage pregnancy partnership was disbanded and in April 2010 a Teenage Pregnancy Executive Board was launched to plan for possible loss of the Teenage Pregnancy Grant in 2011

4.14 There is good multiagency work between identified midwives for young teenage mums and the sexual health team. This has meant that the young mums are well supported and midwives are able to implement early interventions, whenever a child is in danger of becoming at risk. Antenatal liaison is usually effective with good pre-

birth safeguarding planning, multi-agency workshops, and clear vulnerability assessment arrangements which are communicated well between partners including GPs

4.15 Good multi agency working with the sexual health outreach team has resulted in targeted work in secondary schools and academies and is impacting on the sexual health of YP and in the slow but steady reduction teenage pregnancy. The cyber baby project has seen some good individual engagement by YP and there is a lively East Kent website which includes information on drugs and alcohol misuse. Attendance at drop in sessions in schools did vary so school nurses reverted to an appointment system. This along with the identification of an allocated coordinator from the teaching staff in schools ,who gains consent for school nurse to be contacted, has seen improved engagement by CYP, who can then be signposted to other health professionals. Due to some rural localities school is the main point of access these services although outreach services work well in some areas, targeting where young people meet, such as youth clubs.

4.16 Chlamydia screening of 15-24 year olds is effective and Kent has the highest uptake rate of screening in this Strategic Health Authority area. Through increased screening, cases have almost doubled in a year from 1021 in 2008-9 to 1990 in 2009-10. Having implemented the “RU CLEAR” programme as a second wave site, access to testing is available at a variety of locations and 48hrs access to GUM services is well established.

4.17 One area of outstanding practice for children with complex needs was found at East Kent Hospitals University NHS Foundation Trust Kent and Canterbury hospital site. There is a dedicated children’s centre where paediatricians, community nurses, speech and language therapists, occupational therapists and physiotherapists all hold clinics. There is a paediatric physiotherapy gym, counselling and therapy rooms and a day case surgery unit on site in a modern child-friendly and spotlessly clean environment. There is also a nursery and pre-school, run by Ofsted, specifically for under 5’s with physical and learning disabilities and complex needs. Parents are able to access pre-school education for their children, that they may be unable to access through main stream provision. Staff involved with the child will endeavour to see the child on the same day, meaning that parents only have to visit once for all their clinic appointments. Parents spoken to during the visit spoke highly of the service and staff reported positively about this service for which they are justifiably proud. This service represents excellent partnership working between the Acute Trust and Community Services

5 Outcome 6 Co-operating with others

5.1 The PCT and provider services are appropriately represented on the KSCB and sub committees, with named nurses representing health partners on various subgroups. Senior managers have expressed concerns that the KSCB has become very large. This has resulted in difficulties in the decision making process – with

much of the work being carried out through email exchange outside of the meetings and limited resolution of issues

5.2 Whilst individual relationships are good, the two PCT's serving Kent children do not work closely with each other despite plans to combine community health services by April 2011. There are missed opportunities for more effective exchange of ideas, information and initiatives between the community teams with evidence of duplication and some resentment over historical budget differences. Consequently agreement has not been reached on a shared IT system for children's health

5.3 It is reported by the PCT that information from health assessments is shared with carers, social workers and IROs however health information does not sufficiently inform core assessments or looked after children plans nor is it available on children's files.

5.4 There has been a serious lack of concerted action by the partnership to address the disjointed working between child protection services and other key services such as adult mental health, learning disability services, general practitioners (GPs) and CAMHS. This is a major failing given the findings of previous serious case reviews.

5.5 Health partners communicate well in relation to child protection matters despite the deficiencies of the IT system. However, in cases of apparently lower priority, such as children in need, communication and professional links between different clinical disciplines are less evident. There are missed opportunities for more effective exchange of ideas, information and initiatives between the community teams with evidence of duplication and some resentment over historical budget differences. Consequently agreement has not been reached on a shared IT system for children's health.

5.6 Kent health partners have identified specialists domestic abuse staff and health visitors service have developed more targeted additional care packages based around the family risk assessment, with evidence of multiagency work including MARACs

5.7 There is poor connectivity between local health commissioners/providers and out of area councils – there are currently 93 placing authorities, with 42 placing ten or more children. Children with complex physical or behavioural needs are placed in Kent without notification being forwarded to the PCTs, resulting in some cases in unplanned demand on mental health and emergency services. There is a net import of children to Kent with specialist healthcare needs which are currently not always effectively identified and back charged to the referring PCT placing additional pressures on Kent children's health services. .

5.8 Community health staff and GPs report patchy involvement in case planning, with many citing short notice for attendance and lack of understanding of the clinical commitments which may hinder attendance. There are active efforts by PCT managers to monitor attendance by health professionals and ensure that it is

prioritised. There is no evidence of creative arrangements by social services such as video or teleconferencing to facilitate involvement of health colleagues

5.9 Many health professionals reported a lack of feedback on referrals made and particular concerns where cases have been closed by inexperienced social workers due to poor understanding of risk factors highlighted by health staff.

5.10 CAF is widely misunderstood in health across acute trusts and community services. Many staff remember having training three years ago but lack of follow up and experience of abortive and ineffective attempts to use CAF for referral have increased resistance. Staff have some awareness of a recent initiative and appointment of co-ordinators by KCC but staff perceive that initiating a CAF means they are the lead professional and they have neither time nor the IT support to implement this. Only one locality reported the increase of use of CAF due to the appointment of a CAF co-coordinator who is leading on, and promoting its use.

5.11 In East Kent, clinicians in each locality see a number of sexual abuse cases which helps to keep their skills up to date. All cases are referred to the locality consultant community paediatrician and in East Kent; there is good liaison between social care, Police and health. Appropriate environment are in place within the acute hospitals/community settings with colposcopes for examination purposes if required. Experienced Associate Specialists are available, with two of the Community Paediatricians having undertaken forensic training. Clear guidelines are in place, with peer reviews undertaken on a regular basis

5.12 Staff in urgent care centres reported that, in general, partnership working with social care staff is effective where a child or young person is referred to social services with a child in need or child protection concern during working hours. However, there are concerns about requests for consultations made out of hours, reporting that it often takes many hours for a social worker to return their initial call. This can result in staff having to 'hold' children or young people in the department before an informed decision can be made about their onward care. By this time, the family could have discharged themselves against medical advice (resulting in the police being called) or a child being admitted to a ward, even if their medical condition does not indicate admission is required.

5.13 Health staff spoke positively of their experience with individual social workers who they report as being "excellent practitioners". However, they all identified that the 'scaling back' of social worker attendance at key meetings over the last few years has had a detrimental impact on the ability to share information between health and social care at a local level and in a more timely and focussed way. This has particularly impacted in those cases where concerns about a child or family are increasing and where agencies would have previously worked together at an earlier stage to prevent any escalation of potential risk to the child. Health staff reported that this is resulting in social workers only becoming involved when the situation has reached a level 3 or 4 child protection concern and that this is resulting in poorer outcomes for CYP.

6 Outcome 7 Safeguarding

6.1 Named and designated nurses and doctors for safeguarding are in post both within the PCT, Acute and Community Trusts, including named GPs and midwives, although not all contracts and service level agreements reflect these roles or specify sufficient protected time.

6.2 There is very high awareness across all health staff of the need for safeguarding training and supervision and staff report that the latter process being implemented effectively across all health partners. However the impact and outcome of the teams are not formally measured nor their effectiveness monitored

6.3 There is a good working relationship between safeguarding leads in health and staff within the council at team leader level, and concerns raised by staff were usually dealt with through this route but it is not clear how wider system concerns are formally recorded, addressed and actions fed back.

6.4 Thresholds are being applied differently in different parts of the county. Not all agencies appear to understand or exercise their safeguarding responsibilities by ensuring that their referral contains accurate and sufficient information to enable an informed response to be made. Some partners do not have a shared understanding or consensus about the issues and this is preventing progress although some work is taking place in one area to try to achieve a common understanding of requirements

6.5 Learning from serious case reviews (SCR) amongst health partners in East Kent is very good. Comprehensive action plans are drawn up and systematically implemented with monitoring at director level. Throughout the inspection staff were able to demonstrate how learning from SCRs had changed practice and brought people together to address issues raised. There is good partnership working and support from the Specialist Nurse – Child death and the Named and Designated Leads with initiatives such as raising awareness of co-sleeping risks arising directly from SCR's.

6.6 East Kent Hospitals University NHS Foundation Trust operates at five locations – Buckland Hospital (Dover) and the Royal Victoria (Folkestone) both have minor injuries units, Kent and Canterbury Hospital (Canterbury) has an emergency care centre and Queen Elizabeth the Queen Mother Hospital (Margate) and William Harvey Hospital (Ashford) have accident and emergency departments. All sites share the same policies and procedures for safeguarding children and all staff receive safeguarding training appropriate to their role.

6.7 At present, there are a number of different IT systems in use and therefore some units can share information electronically and others cannot. This makes it difficult to track children who may present at a number of different units. Staff report that despite repeated attempts to work with social care and agree an information sharing

protocol, that will allow the development of a 'flagging system' to identify children who are known to social services or who have a child in need or child protection plan, this has not yet been successful. Staff gave several examples of when children had been discharged from the units following treatment where no safeguarding concerns had been identified, only to discover later that the child was subject to a child in need or protection plan. Staff report that although having information about social services involvement would not change their clinical treatment of a child, this information would assist health staff in ensuring that the child was being discharged to a safe environment or appropriate action taken to maintain their wellbeing.

6.8 The Safeguarding Liaison team works across all acute sites. Each unit receives daily visits from a member of the team (except Dover and Folkestone minor injuries units (MIU receive visits three times per week). A member of the safeguarding liaison team reviews all admissions to the departments and in-patient wards. Where concerns have been raised the liaison team will follow these up with the child's primary care team. The safeguarding liaison team keeps their own database so that repeat attenders, or trends of attendance by children and young people can be identified and followed up. The safeguarding liaison team have, in many cases, been able to identify a child or family where there are safeguarding concerns from the information they hold and from their close work with the hospital units. All staff interviewed during the course of the inspection reported that the work of the safeguarding liaison team was critical to information sharing across hospital and community based sites and was fundamental to the effectiveness of safeguarding children in East Kent.

6.9 East Kent University Hospitals NHS Foundation Trust Child Protection Team also hold a database, where all records of contacts, consultations supervision, vulnerable pregnancies and pre birth plans are maintained which again allows the trust to identify a child or family where there may be Child Protection/Safeguarding concerns in a timely fashion.

7 Outcome 11 Safety, availability and suitability of equipment

7.1 There are concerns about the physical environment of the accident and emergency department at the William Harvey Hospital location at Ashford. Previously, there had been a separated area where CYP were seen and cared for but there were insufficient staff to maintain this facility. There is a small separate waiting room for use by children and their families but staff report that this area is difficult to monitor and that during busy times the needs of children may not be met and nurses often have insufficient time to take adequate medical histories. This could result in critical information about the CYP being missed or inadequately recorded. However, the acute trust is aware of this and there is a business case under consideration to improve the physical layout of the department and provide a dedicated children's area. There are also proposals to increase the number of paediatric nurses and introduce a rotation programme so that staff can move between accident and emergency and the in-patient wards to ensure that children can be cared for by paediatric trained nurses.

7.2 The equipment service for disabled children works efficiently across East Kent and staff are clear about responsibilities. The service reports good liaison with health providers. Recycled equipment is made available within 1 week of referral and a monthly order is routinely placed for procurement of new equipment.

8 Outcome 12 Staffing recruitment

8.1 Recruitment policies across the PCT and provider trusts are of good quality and include appropriate checks and criteria. Databases are maintained to monitor renewal dates of membership to professional bodies both for Medical and Nursing staff.

9 Outcome 13 Staffing numbers

9.1 LAC teams comprise of experienced nurses and doctors and there are no vacant posts currently.

9.2 School nurses each support around 28 children with a cp plan within an average caseload of 8637 pupils. Registered nurses in schools have an average of 14 children with a plan within a caseload of 4274 pupils.

9.3 Health visiting caseloads vary across localities between 250 – 450 children. Community staff reported that in some areas not all children are in receipt of child surveillance visits in accordance with the requirements of the healthy child programme and some children are not being seen by health professionals after the initial birth visits, unless concerns are raised following contacts with other health professionals. 6 skill mix teams were introduced some time ago in East Kent but have now been harmonised across NHS Eastern and Coastal Kent Community Services. These are supported by Locality Clinical Coordinators. There are some vacancies (numbers not given) that are being actively recruited to, but it was accepted that this had been a challenge. There are reported to be currently 160 WTE across Early Years provision.

10 Outcome 14 Staffing support

10.1 Child protection and safeguarding training is available at the required levels for all designations of staff across the PCT, Community and Acute providers. Good uptake of clinical supervision is reported by all designations of staff, although evaluation and the impact on service delivery has not been audited

10.2 There is a high level of awareness across all health staff of the need for safeguarding training and supervision. This results in staff feeling well supported by named and designated professionals and frequently cite the quality and availability of the named and designated professionals who support them when working with vulnerable children.

10.3 LAC health staff receive multi agency, multi disciplinary safeguarding training at level 3. Clinical supervision is accessed in a variety of forums – 1:1 by Line Managers, peer and group supervision and also from external sources. Access is also available for specialist areas of supervision ie: Specialist Nurse – Child Death.

10.4 The PCT, Acute and Community Trusts have comprehensive safeguarding training policies in place, with clear monitoring of training completed. It is also detailed in the training strategies, the groups of staff who are expected to undertake each specific level of training

10.5 All staff in the Acute Trust have received level 2 training and approximately 60% have received level 3. All staff undertake the e-learning safeguarding training on induction. Safeguarding training is considered a major priority and any staff members not attending their allocated training received formal letters seeking explanations for absence, to which they are required to formally respond

10.6 Within the community trust, levels one and two safeguarding training is reported to be of good quality, with 50-60 attendees at each session and positive feedback. However there are capacity issues at level 2; whilst level 1 is covered at induction, staff requiring level 2 report difficulties booking onto oversubscribed courses with no more available until late Spring.

10.7 A good practice day was run for health visiting teams in July as part of the review of caseloads and management – this was favourably received in terms of sharing learning and supporting practice and there are plans to make this an annual event.

10.8 Training of GPs in safeguarding is developing but not yet comprehensive. There was an effective workshop for practice nurses recently which has raised awareness and course are held for GPs every 2-3 months.

10.9 There are two recently appointed Child Protection Advisor posts for East Kent Hospitals University NHS Foundation Trust. These staff are managed by the Named Nurse/Midwife for Child protection within the acute trust. They are responsible for supporting the named nurse in implementing the continued training programme in child protection and safeguarding and for additional supervision and support of staff. A CPA is allocated to each of the acute site localities. The Named Nurse/Midwife holds multi-professional meetings across the Trust on a 3 monthly basis which improves communication across health and earlier intervention for CYP

11 Outcome 16 Audit and monitoring

11.1 There is a significant need for investment in IT in the community service. Referrals to/from acute, GPs and social care are conducted by telephone or letter with occasional fax and community staff report poor access to emails, internet and trust-based online facilities such as policies and forms.

11.2 Health monitoring of safeguarding activity is hampered by inadequate community IT systems but there is good management oversight of caseloads and safeguarding activity by the health visiting management team who conduct a monthly review of caseload management.

11.3 Acute trusts have sound governance and reporting systems to monitor training and formal supervision and regular audits of practice are conducted. Monitoring of GP safeguarding activity is not yet developed although named GPs are now in post.

11.4. Performance reports against the health priorities within the CYPP are undertaken by the children's commissioning team and action plans implemented as required

12 Outcome 20 Notification of other incidents

12.1 There are satisfactory arrangements in place across the PCT, Acute and Community Trusts to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC.

13 Outcome 21 Records

13.1 The total number of initial health assessments for LAC undertaken within the four-week statutory timescales to date is unclear. However staff report that once a referral is received the assessments are carried out within approximately 8 weeks. There is a suggestion that there are delays in health partners being alerted by the Local Authority. All health assessments result in a health care plan, detailing identified health needs and there is evidence that outstanding health issues have been addressed or appropriate referrals for health care have been made. Assessments are shared with the social worker and the IRO and other key partners as appropriate.

14 Recommendations (*pertinent ones from the joint report are italicised*)

Immediately:

- To ensure more equitable access to health care services for all looked after children
- To ensure more collaborative working with West Kent PCT in order to implement more effective exchange of ideas, information and initiatives between the community teams in light of the future joining of services.
- (Joint) Ensure that all partners are equally conversant with the threshold for accessing social care services and provide the appropriate levels of referral information
- (Joint) Ensure that all assessments of looked after children are completed to the standards required by statutory guidance, contain the necessary health and educational information and are included on the child's record.
- Ensure that transition arrangements from CAMHS into adult services are improved to support YP more effectively

Within three months

- (Joint) Establish systematic performance management processes at all levels to improve the quality of practice and management across the partnership.
- Audit, monitoring and analysis of safeguarding data should be used more efficiently to ensure that health services are appropriately resourced and risks identified
- (Joint) Improve the child protection conference process to ensure that professionals are properly prepared and service user confidence is restored.
- Health partners should ensure that CAF is more effectively promoted and implemented to improve understanding of the process and monitor referral rates and thresholds

Within six months

- (Joint) Review the [safeguarding] workforce and take the necessary steps to address capacity and capability shortfalls.
- (Joint) Develop a multi-disciplinary looked after children strategy and clarify management and leadership roles and accountabilities

- (Joint) Develop a screening tool for substance misuse for use with looked after children and young people
- Ensure there is a clear strategy and plan for the health care of all LAC in Kent including annual reporting function to the PCT board and KSCB
- Ensure that developments in ICT across community providers link effectively with partner agencies to improve communication for children's health and safeguarding

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC.