

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

Date of Inspection	11-22nd October 2010
Date of final Report	2nd December 2010
Commissioning PCT	NHS West Kent
CQC Inspector name	Sue Eardley
Provider Services Included:	Maidstone and Tunbridge Wells NHS Trust. Dartford and Gravesham NHS Trust Kent and Medway NHS Partnership and Care Trust West Kent Community Health
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 (LAC) 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	Inadequate

and young people	
Capacity for improvement of the council and its partners	Adequate

This report includes findings from the overall inspection report, *(these are in italics)* 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 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 LAC 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 Eastern and Coastal Kent and NHS West Kent.

Community services for West Kent children are provided by West Kent Community Health (WKCH) which is part of NHS West Kent, the PCT. Community paediatrics are part of the community trust in West Kent. Acute hospital services including maternity and accident and emergency care for West Kent are provided by Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust (not visited as part of this inspection). Specialist Child and Adolescent Mental Health Services (CAMHS) in West Kent are provided by Kent & Medway NHS & Social Partnership Trust (KMPT) which also provides adult mental health services across the county.

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 Within West Kent's PCT and acute trusts there is a strong strategic awareness of the importance of safeguarding. Board level reporting is good, particularly in the two acute trusts and the commissioning arm of the PCT, with safeguarding issues regularly discussed as a standing item. There is scope for developing more outcome-focussed performance measures, particularly for West Kent Community Health. There is good evidence of learning from Serious Case Reviews (SCRs) across health partners at all levels and the positive impact of the named nurses and the safeguarding advisers in supporting staff is evident. Safeguarding policies and procedures are sound and available to staff in all locations visited and there is an extremely good system of safeguarding supervision in place across all services inspected.

1.3 Involvement of West Kent PCT and health partners in the governance of the Children's Trust is adequate but there was little evidence of top-to-bottom engagement with the health priorities of the Children and Young People's Plan (CYPP)

1.4 There is evidence of children's healthcare being delayed by funding and contractual discussions and some reliance on individual staff knowing the system rather than consistent and effective referral and support services and use of tools such as the Common Assessment Framework (CAF). Services are under extreme pressure in some areas resulting in delays in assessment and treatment particularly for CAMHS services. Gaps in the universal commissioned service for CAMHS for young people between 16 and 18 years are a concern although there are arrangements to cover CAMHS need for LAC. Commissioning of children's health services in West Kent is combined with the adult block contract except for CAMHS and community services which makes contractual impact and monitoring less flexible.

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 with those placed from out of area having no priority access to services such as CAMHs. There are poor systems for monitoring children placed in Kent and recharging source PCTs. Statutory responsibilities such as annual reporting on the health of LAC are not complete, the quality of health assessments is reported to be patchy and despite recent management initiatives and the rollout of an integrated LAC support service by the Authority there remains a lack of information and strategic planning for improving the health of children who are looked after.

1.6 Tier 4 CAMHs services are inadequate, with insufficient inpatient capacity resulting in regular use of adult wards for emergency accommodation of under 18s, although their CAMHS needs are met and transfer is arranged swiftly. Currently the closest secure adolescent ward is Oakwood in Surrey but plans are in place for a re-commissioned service including a specialist Section 136 suite in Staplehurst.

1.7 Whilst individual relationships are good, the two PCTs 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.

1.8 A robust system for securely sharing information about children across services is not in place – a recent joint IT procurement exercise for East and West Kent did not identify an agreed system and a workable mechanism should be designed as a priority.

2 Outcome 1 Involving Users

2.1 User involvement within health services is variable with some areas of good practice, particularly around sexual health outreach where feedback from surveys has resulted in changes to drop-in clinic times and venues. Young people are involved in staff recruitment in drug and alcohol services and as 'mystery shoppers' [by the CASH team in West Kent] to evaluate responses to requests for services.

2.2 A survey of LAC is being developed within West Kent but there is no apparent liaison with East Kent around their established findings or method. A West Kent LAC nurse led the successful "get GOK'd" programme (named after stylist Gok Wan) which focussed on body image, improving self esteem and health awareness amongst a group of teenage looked after girls and there are plans to extend the programme.

2.3 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.

2.4 The Romany and Slovakian community in Gravesend presents some challenging health and safeguarding needs across families. Community health

teams in West Kent have linked with an external specialist to gain access and establish a multi-agency working party and there are plans for a joint funded worker to provide admin support and signposting of needs. There are huge needs - with a report of 17 referrals at one time by the Surestart social worker. There is good work by local social care staff who are supporting the work of the health visitors.

2.5 Generally engagement with children and young people, families and carers from minority groups is good and staff interviewed could all cite examples of effective work.

2.6 Practitioners working with asylum seeking children, children with disabilities and the Romany communities demonstrate clear commitment to effective communication using trained professional interpreters, although not all of those used by health professionals are considered to be suitably independent

2.7 Access to translation services across Kent is variable; West Kent trusts use local translators and Maidstone and Tunbridge Wells NHS Trust maintains a register of multilingual staff who have received basic training. There is no link between the contracted interpretation services for health partners and the Council. Some staff in Maidstone and Tunbridge Wells NHS Trust reported that family members were occasionally used which is inappropriate and others across providers felt that interpreters from minority communities may not be considered by service users to be wholly independent.

2.8 There has been some early involvement of representative groups in planning service developments, for example, the reconfiguration of the West Kent community nursing service was launched with a workshop including families of disabled children and another is planned around continuing care in November, with a user satisfaction survey currently being conducted. The Drug and Alcohol team (KCA) is developing two forums across Kent comprising current or recent service users. Young people participate in the recruitment process for staff, and are involved in service planning and commenting on development work.

2.9 There is little evidence amongst health partners of adoption of the "You're Welcome" adolescent-focussed involvement and awareness programme although this is cited in the teenage Pregnancy Strategy as an objective.

3 Outcome 4 Care and welfare of people who use services

3.1 Initial health assessments for looked after children from Kent are carried out by dedicated doctors although a vacant post in the West Kent area is creating pressures. 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%). 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 a GP although they are unable to confirm this from their records. Rates of immunisation at 92% exceed comparator 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 latest statutory annual health report in relation to looked after children has not been produced by either PCT.

3.2 Staff report that once a referral is received health assessments are carried out within approximately 8 weeks. All health assessments result in an action plan detailing identified health needs and evidence that outstanding health issues have been addressed or appropriate referrals for health care have been made, and the assessments are shared with the social worker and the IRO. There is currently no service specification which outlines this service delivery.

3.3 Ongoing health needs are dealt with by the LAC team and staff report that access is good for LAC from Kent for dental care, opticians and speech therapy and checks are up to date. For LAC from out of Kent, there are delays in accessing treatments and delayed referrals, which is due mainly to the LAC health team being unaware of information about exactly where these children are placed and of the total numbers. This particularly relates to children who are in independent foster placements

3.4 The 3 district-based LAC team arrangements are under review with appointment of a new manager in February 2010. An analysis of roles and responsibilities, recent access to the ILSS database and increased profile of the team (for example by presenting at induction training for all new children's services staff) indicates potential for improvement but it is too early to demonstrate impact on outcomes, and monitoring of quality and involvement of children is not yet established although staff are experienced and work hard. The designated doctor role is allocated but not confirmed in contractual arrangements.

3.5 Child and adolescent mental health (CAMHS) support for looked after children is inadequate with excessive waiting times for services, inconsistent community provision for young people aged between 16 and 18 years and no fast track access to services. The service that has been recently commissioned to provide specialist specialist support and advice to professionals working with children with significant mental health problems is providing a responsive service but its impact on the overall demand across the county is limited.

3.6 Kent CAMHS has recently been visited by the CAMHS National Support team and the report makes a number of significant recommendations relating to strategic leadership and development of the services. Kent and Medway NHS and Social Care Partnership Trust has been encouraged by the LSCB Chair to consider a number of steps to improve audit service quality and practice and develop an effective vision to improve the contribution to safeguarding of Kent children.

3.7 Referrals into CAMHS are made to the cross-Kent LAC CAMHS team, and there are contractual differences depending on the source authority. Staff in the service reported that each child referred is dealt with according to clinical need at

that time regardless of looked after status; they do not differentiate between LAC or not LAC i.e LAC do not have fast track access to CAMHS although there is a specialist therapeutic service for Kent LAC being commissioned by the ILLS team and hosted by KMPT which aims to support the teams working with young people who require a Tier 3 service. The programme currently covers West Kent, Medway and part of East Kent and the service reports short waits of less than one month for assessment and commencement of the programme.

3.8 Transition from child to adult mental health services is poor. Commissioning arrangements for CAMHS services between 16 and 18 years are unclear; some young people 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 200 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 sometimes these YP are, the next day, found to be under 16yrs

3.9 The universal CAMHS service at level 2 is inadequate across Kent, with long waits (up to a year), uncertainty about thresholds amongst referring practitioners, poor feedback to referrers on outcomes, insufficient use of CAF and under resourcing for work in schools and community services. Tier 3 CAMHS across West Kent is extremely stretched with cited caseloads of 370 against a commissioned caseload of 80 (and Royal College guideline of 40) and waits reported by community staff to be up to nine months, although the trust cites 16 weeks. Medical staff considered that up to half of these cases could have been dealt with at Tier 2 with appropriate therapy in schools although improved awareness within community settings has increased identification and referral rates. There is insufficient rigour in contractual definition and eligibility criteria for referral are not clear.

3.10 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 usually avoid crisis situations due to targeted interventions by school nurses. The “Make your Child Shine” initiative is working successfully in primary schools to support parental involvement in addressing T2 needs in their children.

3.11 In West Kent a group of GPs have directly commissioned a CAMHS nurse to provide rapid assessment of young people with treatment or referral as appropriate. This service is highly valued and early indications are that there is impact on instances of deliberate self harm amongst the young people she serves.

3.12 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 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.

3.13 Chlamydia screening of 15-24 year olds is effective and Kent has the highest rate of screening in the SHA area. There is good partnership with Marie Stopes clinic which also carries out “opt out” testing on all attendees. Through increased screening, chlamydia cases have almost doubled in a year from 1021 in 2008-9 to 1990 in 2009-10.

3.14 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. There are a number of good initiatives taking place in local areas, such as the “R U Ready” course and Speakeasy but whilst individual schemes are remarking on fewer pregnancies within, say, individual schools there is insufficient recorded evidence of sustainable impact across the various services,

3.15 There are good sexual health outreach services in West Kent, with nurse-led services in many schools and drop in clinics with medical presence, and some positive initiatives with boys and young men. There are good links with the school nursing team. Referrals and communication between teams relies on telephone and mail contact as there is poor IT connection between services. Referrals to social services are challenging since many administrative staff are part time and don't have access to computers, requiring them to make referrals out of their normal working hours.

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

3.17 The “big blue bus” scheme in West Kent and Medway takes health and wellbeing messages (including sexual health and alcohol awareness) to young people where they are including a Friday night presence in areas where young people socialise and in the town centre at the end of term. This scheme is reported to be working well with good engagement although its longer term impact is difficult to measure

3.18 Speech therapy services in West Kent are inadequate due to access problems – the service came from Medway PCT early 2010 with a large backlog and the current wait in Dartford is 18 months – the service is being reorganised and an interim triage service is being introduced against criteria for entry to the service. Other therapy services are pressured. Parents/carers are invited to telephone to make suitable appointments at a time of their choosing. This has resulted in reduced Did Not Attend (DNAs) and better meets the needs of families; those failing to phone or attend are followed up through GP notification but it is not clear whether this arrangement is sufficiently effective in picking up possible neglect issues.

3.19 Child and adult substance misuse is a priority of the CYPP. Referrals to the KCA drug and alcohol service team have increased by one third in number from 2008-9 (505) and 2009-10 (743), which indicates better access to the service rather than greater need. The service is highly respected and teams work effectively in partnership with other practitioners, and provide targeted specialist interventions in children's homes and schools if required.

3.20 Community nursing staff in West Kent are employed by the acute sector in Maidstone and by WKCH in Dartford. Plans are in place to bring the team together within WKCH, remodelling the service to increase efficiency and effectiveness, and there is a suite of good performance indicators being developed. Delays in staff transfer have raised concerns about whether the service transformation will be complete on schedule and there is a link to the new model of care designed around the new children's unit which opens in Pembury hospital in July 2011.

3.21 There remains some reliance on voluntary provision of community nursing services in some areas and across the county (eg Maidstone) the opportunity for life-limited children to die at home, for example, is not available.

4 Outcome 6 Co-operating with others

4.1 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.

4.2 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.

4.3 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.

4.4 PCTs 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.

4.5 CAF is widely misunderstood in health across acute trusts and community services, although the aim of Community healthcare managers is to implement e-CAF as soon as IT facilities are available. Many staff recall 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 early intervention teams 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 (Dartford) reported the increase of use of CAF due to the appointment of the early intervention co-ordinator who is leading on, and promoting its use.

4.6 The Kent Drug and Alcohol team (KDAT) are all CAF trained and attend core meetings, taking lead professional role if appropriate. They link well with GPs and health visitors. KDAT have invested heavily in safeguarding, developing assessment tools for primary care and leading on implementation of the Hidden Harm strategy which was formally launched during the inspection. The strategy indicates that “Hidden Harm” work with parents and carers who may be abusing substances is still at an early stage and whilst initiatives are in place such as adapting the adult assessment tool to include assessment of parenting capacity, file audits of, for example, adults in treatment who were pregnant, there is no evidence yet of impact.

4.7 Links with CAMHs, adult mental health services and social services are in some cases not effective, with examples of children in need and their parents being separately seen by mental health services and no communications between services or with social care.

4.8 Links between acute and community services within health are adequate, and there are local attempts to ensure that communication of relevant safeguarding information is effective in the absence of a linked IT system. In Maidstone and Tunbridge Wells there is significant reliance on a single individual, albeit supported by paediatric nurses, to maintain and manage the referral and communications systems for A&E and other children’s services although the trust has recognised this and is recruiting a liaison health visitor and paediatric A&E nurses to improve support. There are concerns about cross-border liaison for mental health, with reports of some young people with mental health need waiting longer than necessary in A&E whilst negotiations take place about responsibility for their care.

4.9 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.

4.10 There are good links between Maidstone and Tunbridge Wells Trust and social services, particularly in neonatal care, but social workers appeared to be reluctant to add comments to clinical notes despite encouragement

4.11 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 to health services. This notification would enable PCTs to recharge the referring PCT for the appropriate funding rather than drawing on

existing resource invested for Kent's children and improve the timeliness of care provided to children from out of area. LAC nurses are involved in all training courses for foster carers covering key health and wellbeing topics, and report good access to children's homes, linking with in-house nurses where appropriate.

4.12 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 to monitor attendance by PCT managers and ensure that attendance is prioritised, with reports being submitted where attendance is not possible. There is no evidence of creative arrangements by social services such as video or teleconferencing to facilitate involvement of health colleagues

4.13 There is an excellent "Risk-it" research project being assessed - led by KDAT - identifying adolescent risk-taking behaviour such as drugs, alcohol, violence and sexual activity. The project screens a school year group using validated tools and determines 15 risk takers per class; the top 6 receive 8 group based sessions and 3 one to ones. The programme links to family group conferences and all agencies provide support and input. Impact is being measured across the range of services-offending, education, etc and all show positive outcomes so far. Schools are keen to keep going despite extra resource needed to run it. Young people are assessed on commencement about activities they were involved in during the 28 days before and again 6 months after the course. The programme is linked to enhanced healthy schools criteria and schools get feedback to assist the wider group. It is hoped the programme will be rolled out once the research is complete.

4.15 Whilst WKCH is not contracted to provide a specialist domestic abuse service, Specialist Community Public Health Nurses (SCPHN) do consider domestic abuse within their family risk assessment. Where cases of domestic abuse are identified or suspected, SCPHN services will provide targeted care packages, support and advice, as appropriate to their role with the family, eg, signposting and referring to social services, listening visits, and provision of information to local Multi-Agency Risk Assessment Committees (MARAC) which is reported to be working well.

4.16 All staff from KDAT are trained in Domestic Violence recognition and management through a tailored course specifically designed for the work of the team. Staff across the services reported that domestic violence training in the area was good but difficult to access.

4.17 West Kent community therapy staff have good referral systems and backup and work to a child's child protection plan with appropriate support from safeguarding leads – for example, a disclosure at home was referred through school and follow up was appropriate

4.18 Community health staff report that feedback from referrals to social care is patchy and cite examples where referrals have been closed then reopened on challenge. It is not clear how this is being addressed through the KSCB and its working groups. KCC have recently published "access and eligibility criteria" for referral to social care following discussion with partners which is being trialled prior to full implementation.

4.19 There are good links with the Youth Offending Service, with clear access pathways to CAMHs support. Access to forensic services was however reported to be difficult.

4.20 Excellent safeguarding links were reported with the Ambulance service; concerns are notified swiftly to the safeguarding team, both for safeguarding and child death, where early notification is useful. There are good links through the police for alcohol issues. There are examples of paramedics picking up useful safeguarding information from incidents, such as room temperature, environment, and also providing support and advice to parents.

5 Outcome 7 Safeguarding

5.1 Named and designated nurses and doctors for safeguarding are funded in post, including GPs and midwives. However, contrary to statutory guidance not all contracts and service level agreements reflect these roles or specify sufficient protected time. For example the designated doctor also covers the named role and has just one session contracted for these duties.

5.2 Maternity safeguarding systems are good - particularly at Darent Valley, with effective communication amongst the team; but systems of birth notification to health visitors from all acute units require paper links and there are instances where updated address details have not been passed on by the maternity team.

5.3 The MIMMS project has been running in West Kent for ten years and is now being rolled out across the county. In the absence of Mother and Baby mental health beds in the county, the MIMMS service aims to address issues of maternal mental ill health, protecting both mother and baby from harm. Women are identified early in pregnancy by health professionals and referred to the service, which works with the woman, her partner and health professionals to mitigate mental health problems and support the mother for up to a year postnatally. There are currently 200 women being supported and the project is also raising awareness of the issues and management techniques amongst other health professionals, enabling them to provide direct support. Women placed in M&B units out of county are visited and partners are supported as part of the scheme. Performance indicators include reductions in need for mother and baby unit places and positive feedback from audit although longer term reduction on pressure on mental health and family support services are anticipated.

5.4 A&E alert systems work well and there are good protocols in place (from July 2010) which include urgent care centres, MIU and walk-in settings, and define response targets across partners. There is no automatic linkage to the social services list of those children or young people with a child protection plan. Within both acute settings the local safeguarding liaison team therefore monitor all children's casualty cards by daily visits to A&E and to Urgent Care Centres, providing immediate advice where staff have concerns.

5.5 Responsiveness of council's children's services team to referrals and enquiries from emergency care was not cited as a problem but health staff generally avoid

using the contact centre and go direct to staff they know within the service. Some 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. 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.

5.6 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.

5.7 Many GPs reported insufficient notice to attend case conferences and strategy meetings but there is no evidence that senior health staff on KSCB have fed his in, for example considering teleconferencing. There are reports of excessive requirements for input to case conferences and further dialogue is needed with social care to improve the mutual understanding of how GP input adds value.

5.8 Some health partners report satisfactory dissemination of learning from serious case reviews however the experience of front line social care staff is that current arrangements for dissemination of learning and improving practice are inadequate.

5.9 Learning from serious case reviews amongst health partners 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 Named Nurse/Child death lead and the Named and Designated Leads with initiatives such as raising awareness of co-sleeping risks arising directly from SCRs.

5.10 It was reported that dentists are signed up to the safeguarding agenda – there is a named dentist and training programme is being rolled out

5.11 Out of hours care is provided through a contracted service, which is currently being reviewed. Many of the doctors are local GPs but it was not clear what arrangements are in place to provide assurance about competency and training in safeguarding. All reports only go back to the child's GP and is not clear how or whether safeguarding referrals are made to the wider team.

5.12 The Sexual Assault Referral centre (SARC) provides an effective clinical service with good buy-in from paediatricians locally but a recent review identified a lack of formal governance, leadership and "ownership" across partners. The Forensic Medical Examiner (FME) service is funded 9-5 weekdays but there is no provision for evening or weekend emergency examination. The only forensic suite is in Dartford in the North West of the county meaning long transit times and the

facilities require expansion and are not child or adolescent focussed. Around 10-12 CYP a year use the forensic suite, and support for staff out of hours by the CAMHS team for adolescents was cited as a concern . There are some concerns about police responsiveness in identifying children who may have been sexually abused.

6 Outcome 11 Safety, availability and suitability of equipment

6.1 However the accident and emergency facilities for children at the Maidstone hospital site are inadequate. There are no children's nurses, the children's area is insufficiently separate or secure from adult care and adults' and children's major injury cases are seen together. Plans are in place to improve the quality of services through recruitment and relocation to a more suitable environment.

6.2 The equipment service for disabled children works smoothly in West Kent and staff are clear about responsibilities, with recycled equipment being available within 1 week, and a monthly order being placed for new equipment. .

7 Outcome 12 Staffing recruitment

7.1 Recruitment policies at the two acute trusts are of good quality and include appropriate checks and criteria.

8 Outcome 13 Staffing numbers

8.1 LAC teams comprise experienced nurses and doctors and there are no vacant posts although the designated doctor role in West Kent is not formally contracted. Staffing levels with the LAC teams are tight and the medical service is stretched in West Kent with two vacant paediatric posts and a lack of integration amongst the three districts.

8.2 Community staffing numbers are tight in West Kent, with reported health visiting caseloads in May of over 517 children per health visitor. Over 50% of health visiting work in West Kent is child protection, resulting in less early parenting support and surveillance work. Of the healthy child programme, only newborn and one year checks are routinely conducted, with additional care targeted only to the most vulnerable families

8.3 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.

8.4 Turnover within West Kent community teams is low but absence of staff on secondment, long term sickness or maternity leave is adding pressure to existing teams. Morale is reasonable and a recent review of teams and case mix had modified working arrangements and improved cross-district working. For example, case conference attendance is seen as a priority and health visitors, school nurses or safeguarding advisors liaise to ensure the most appropriate or available team member attends and feeds back. There is a monthly review of

caseloads and redistribution where required to mitigate pressure on individuals. New staff are inducted carefully with reduced caseload and increased supervision until considered ready to take on a full load.

9 Outcome 14 Staffing support

9.1 There is very high awareness across all health staff of the need for safeguarding training and supervision, with the latter process being implemented effectively across all health partners where retention is comparatively high. This results in health staff feeling well supported by named and designated professionals in carrying out their safeguarding responsibilities. However the impact and outcome of the teams are not formally measured and their effectiveness is not evaluated or monitored.

9.2 LAC staff receive multi agency, multi disciplinary safeguarding training at level 3. Clinical supervision is accessed in a variety of forums – 1:1 by Line Manager, peer and group and also external sources. There is access to specialist areas of supervision, such as LAC, Named Nurse/ Child Death lead, and there is good uptake of clinical supervision reported by all designations of staff although the impact on service delivery has not been audited.

9.3 Both acute trusts had good safeguarding training policies in place, with clear monitoring of training completed and analysis of which groups were expected to undertake which level of training. A training DVD has been produced by MTW to facilitate individual learning.

9.4 Healthcare staff in Kent feel well supported in carrying out their safeguarding responsibilities and frequently cite the quality and availability of the named and designated professionals to support them when working with vulnerable children.

9.5 Within WKCH, 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 2011.

9.6 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.

9.7 KMPT staff are extremely pressured which restricts the capacity of training and implementation of new initiatives such as the Solihull approach. Whilst KMPT staff receive supervision from the named nurses there is a concern that the named nurses themselves are expected to receive safeguarding supervision from their line manager rather than from the designated nurse.

9.8 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 Outcome 16 Audit and monitoring

10.1 There is a significant need for investment in IT in the community service to support and monitor safeguarding activity. - referrals by health visitors and school nurses to/from acute, GPs and social care are conducted by telephone or letter with the occasional fax and community staff report poor access to emails, internet and trust-based online facilities such as policies and forms.

10.2 The health visiting management team has good oversight of cases and conducts a monthly review of caseload management, for example children in need and disabled children. Audits of records management are ongoing but there are no findings or action plans yet.

10.3 The absence of up to date, online CHIN and CP information within emergency care settings is a concern, relying on individual staff monitoring attendance every day and manually flagging records where appropriate. Until the online information is made available by KCC, an agreed Kent –wide protocol for information flows and systems around urgent and emergency care is in place, which includes the walk-in centres and minor injuries units.

10.4 Contrary to statutory requirements, the PCT and partners have not produced a statutory annual LAC health report since 2007. Monitoring of community services for reference costing is recent (2 months), not comprehensive and where conducted is based on inputs and process data. There is little evidence yet of the data being used for service planning or a link to quality of outcomes, and out of area referrals are not yet being effectively negotiated in terms of cross-charging arrangements.

10.5 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 by the PCT is not yet developed although a named GP is now in post.

10.6 The community trust is developing performance indicators for safeguarding but these are currently process measures, focussing on training, supervision and recruitment and not yet looking at outcomes or effectiveness. There is a range of public health material and audit work on family needs assessment, record keeping, etc.

10.7 KMPT trust carries out regular audits of practice – they are members of CORC and are developing safeguarding measures since the National Indicator 51 is ceasing. The service currently uses the Strengths and Difficulties Questionnaire (SDQ) in line with the national Indicator but is now moving to HoNOS to measure individual outcomes.

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

Immediately:

- (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) *Establish clear arrangements for the referral and treatment of young people aged 16-18 requiring a CAMHS service*
- (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.*
- (Joint) *Improve the quality of case planning and ensure that all relevant professionals are able to participate and contribute to the process.*
- West Kent PCT to improve audit and monitoring of LAC needs and outcomes in order to ensure that an equitable and compliant service is in place for children living in Kent .

Within three months

- (Joint) *Establish systematic performance management processes at all levels to improve the quality of practice and management across the partnership.*
- *Health partners improve audit, monitoring and analysis of safeguarding data to ensure the service is properly resourced and risks identified*
- (Joint) *Improve the child protection conference process to ensure that professionals are properly prepared and service user confidence is restored.*
- (Joint) *Ensure that each service subscribes to a suitably independent interpreter service*
- (Joint) *Ensure that all looked after children can access CAMHS up until 18 years of age*
- Health partners engage with locally agreed CAF arrangements to improve understanding of the process monitor referral rates and thresholds
- Ensure that the out of hours GP service includes clear arrangements for safeguarding, including training and supervision of practitioners.
- Complete the strengthening of support arrangements for safeguarding in MTW particularly in A&E.

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*
- 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 for community providers link effectively with partner agencies to improve information flows 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 through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.