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

Date of Inspection	**March 21 – April 1 2011**
Date of final Report	**12th May 2011**
Commissioning PCT	**Doncaster Primary Care Trust**
CQC Inspector name	**Lea Pickerill**
Provider Services Included:	**Doncaster PCT** **Doncaster Community Health** **Doncaster & Bassetlaw Hospitals NHS Foundation Trust** **Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust**
CQC Region	**North East**
CQC Regional Director	**Jo Dent**

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

Doncaster County Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
Contribution of health agencies to keeping children and young people safe	Adequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being Healthy	Inadequate

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.

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:

Doncaster has a resident population of approximately 72,000 children and young people aged 0 to 18, representing 24.7% of the total population of the area. In 2010, 10.7% of the school population was classified as belonging to an ethnic group other than White British compared to 22.5% in England overall and 0.75% of pupils are of Gypsy, Roma or Traveller background. Some 6.3% of pupils speak English as an additional language. Polish and Urdu are the most recorded commonly spoken community languages in the area.

The Doncaster Children's Trust was set up in January 2010. The Trust includes representatives from the Doncaster Youth Council, NHS Doncaster, South Yorkshire Police, South Yorkshire Fire & Rescue, Chamber of Commerce, Voluntary & Community Sector, Jobcentre Plus and representatives of the Council, local schools and colleges. The Doncaster Safeguarding Children Board (DSCB) became independently chaired in 2009, bringing together the main organisations working with children, young people and families in the area that provide safeguarding services.

Commissioning and planning of national health services and primary care are carried out by Doncaster NHS Primary Care Trust (PCT). The main provider of acute hospital services are Doncaster and Bassetlaw Hospitals NHS Foundation Trust. Community-based Child and Adolescent Mental Health Services (CAMHS) are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). In-patient CAMHS is provided via block purchase regional arrangements provided by Sheffield Children's Hospital with additional spot purchases by specialist providers. The Community Provider Unit Doncaster NHS PCT provides community health services, which on 1 April 2011 transferred to RDaSH. (Ofsted, May 2011)

1 General – leadership and management

1.1 The impact of a stable and permanent executive management team for Doncaster's Local Authority children's service has had a positive influence on the relationship with health partners. The review of the local strategic partnership with the development of the "Doncaster Together" approach has been embraced and it is evident that the safety of children living in Doncaster is seen as a collective responsibility.

1.2 Health partners were able to confidently and enthusiastically describe how the recent changes to the children's trust partnership and the Doncaster Safeguarding Children Board were instrumental in driving forward the improvement agenda for safeguarding children and young people.

1.3 There is currently a gap in specific Looked after Children health needs analysis, although components of this are covered within the general health needs analysis within the JSNA. The Health Observatory work plan for the coming year includes specific Looked after Children health needs analysis.

2 Outcome 1 Involving Users

2.1 There is evidence of good user feedback influencing the provision of the speech and language therapy services (SALT) provided by Doncaster & Bassetlaw Hospitals NHS Foundation Trust. In response to patient satisfaction surveys, parents and carers had said how they disliked having to attend a centralised service in the centre of town. The SALT reconfigured its service and now has well established and well used clinics across Doncaster, with very low numbers of families failing to keep appointments.

3. Outcome 4 Care and welfare of people who use services

3.1 The midwifery service in Doncaster has good arrangements in place to identify vulnerabilities in pregnancy. The midwives carry out a comprehensive risk assessment around substance misuse, domestic violence and emotional health and wellbeing on three separate occasions throughout the pregnancy. This helps to ensure that any changes to a woman's circumstances are responded to. There has been no audit on record keeping within midwifery, though this is planned for 2011/2012.

3.2 There is good support available to women who are pregnant and have a drug or alcohol problem. The substance misuse midwife works closely with the adult substance misuse service, Garage, either as the pregnant woman's key worker or as part of a shared care agreement. She will offer advice and support to community midwifery staff where the woman chooses to remain with universal services or will provide the whole ante natal service if appropriate. There is a weekly joint ante natal clinic held with a consultant obstetrician with a special interest in substance misuse. This specialist ante natal clinic is highly regarded by the women and a recent audit has shown that all the women who have appointments at the clinic attend them.

3.3 There is good support offered to teenagers who are pregnant through the work of the teenage pregnancy midwife. The midwife holds a small number of complex cases and supports community midwives who may have pregnant teenagers as part of their caseload. The specialist midwife runs a dedicated ante natal clinic, with consultant obstetrician input, for pregnant teenagers. The clinic is well attended.

3.4 The Family Nurse Partnership (FNP) offer good support to vulnerable first time teenagers that are pregnant. The FNP is available to support vulnerable teenagers from 16 weeks gestation through to when their child is 2 years old. There is good evidence of engagement with good retention throughout the programme. A recent evaluation of the service demonstrates improved health outcomes, including changes in smoking behaviours, improved engagement with fathers and improved weight of babies.

3.5 The health visiting and school nursing services provided by Doncaster Community Healthcare are good. The healthy child programme is delivered through integrated teams consisting of health visitors, school nurses, community staff nurses, nursery nurses, school nurse assistants and family support workers. All cases are weighted according to complexity of need with a corresponding adjustment to caseload numbers to ensure that practitioners are able to meet the demand for their service. The health visitors provide the core offer, including ante natal contacts and 2 year checks. There are adequate arrangements in place to transfer children from the health visiting service into the school nursing service. Face to face meetings take place between the health visitor and school nurse to discuss children where there are identified needs. The school nurse, as well as attending the "new into school" reception parent meetings, also carries out the core contacts including the weighing and measuring of children as part of the child measurement programme and vision and hearing checks. The school nursing service is currently exploring how it can introduce a contact with young people who are leaving statutory education. There is a named school nurse for each secondary school within Doncaster.

3.6 The special schools in Doncaster receive good support from the team of advanced nurse practitioners for schools who provide nursing care to the children and young people as well as supporting school staff in care giving.

3.7 The CAMHS are adequate. The CAMHS has undergone significant service reconfiguration including a change in provider. As part of the transformation there is some outstanding work required to reconcile the new model of service with the existing workforce. The new service is for children and young people up to the age of 18 and offers a range of early intervention support, consisting of between 6 and 8 sessions, or more specialist or long term support dependent on need.

3.8 There is a single point of access to the service using the Choice and Partnership Approach (CAPA) where all referrals are considered and individuals offered a choice appointment with an appropriate practitioner. The service is working to introduce targets for all referrals being assessed and an appointment offered within 2 weeks of the referral being received, with the first intervention taking place within 4 weeks of the referral being received. Currently, there is a wait of between 8 to 10 weeks for the first appointment, with no waits for core services, though there are some delays in accessing specialist services such as family therapy or art therapy.

3.9 CAMHS have moved away from the previous clinic based settings and now offer consultations in a range of community bases or in the family home, wherever is most appropriate. There is a duty CAMHS team that operates during normal working hours and will carry out emergency assessments and offer support to the paediatric wards. There are no local in- patient beds for young people who require admission, these are commissioned from a neighbouring trust. In addition, there are two beds identified on an adult ward for use in an emergency. There are clear protocols and reporting mechanisms in place if these emergency beds are utilised and ward staff are supported by the named nurse with additional safeguarding children supervision and advice.

3.10 The care pathways for young people diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) are inadequate. Currently, the CAMHS offer an assessment and diagnostic service after which the child or young person is then referred to the community paediatricians for treatment. This can involve a wait of up to 9 months, by which time the community paediatricians repeat the assessment and diagnostic tests before commencing any care package. Parents spoken to expressed their concerns around the imminent departure of one of the prescribing paediatricians as they understood that the remaining paediatrician did not prescribe.

3.11 Where practitioners feel that a child or young person is displaying behaviours associated with the autistic spectrum, then a referral is made to the multi agency and multi disciplinary Social Communication and Difficulties Panel for assessment and diagnosis. This service appears to work well and there were no problems or delays reported.

3.12 CAMHS support for children and young people with learning disabilities is inadequate. There are two specialist learning disability practitioners who are supported by a consultant child psychiatrist with a dual qualification. The consultant child psychiatrist is commissioned from Sheffield and provides a full day clinic once a week. Waiting times to access the consultant are approximately 2 years. This means that some of the most vulnerable families may not be receiving appropriate care and support.

3.13 CAMHS take referrals for young people up to their18th birthday though they aim to work flexibly with adult mental health services on individual cases to try and ensure that any new referral is accepted by the service that can best meet the need. The transition arrangements for young people from CAMHS into adult mental health services is adequate. There is recognition that the arrangements for transition require further work and this is an area identified by the trust for development. There is good partnership working through the early intervention psychoses team which care for young people from 14 to 35 years and the intensive support community team which is an adult based team that provide advice, assessment and support to adults with asperger's syndrome, post traumatic stress or personality disorders.

3.14 Staff interviewed were unable to provide details of any mechanisms in place to capture feedback from children, young people and their carers on the CAMHS services provided. It is too early to measure the impact of the service transformation for core CAMHS on outcomes for children and young people.

3.15 There is good support offered to families and carers of children and young people with complex health needs. As well as the standard therapy services, Doncaster PCT commissioned the Doncaster & Bassetlaw Hospitals NHS Foundation Trust to provide a therapy service to children and young people who had long term, complex health needs and that were in education. The multi disciplinary team of speech and language therapists, occupational therapists and physiotherapists operate through a single point of access that accepts referrals from professionals as well as parents and carers. A significant factor in the success of the team has been through the work carried out by the Child Support Workers (CSW) who bridge the gap between health teams and education and deliver the care programmes under the supervision of the relevant therapist. The team have good multi agency networks across health, social care and education. The parent forum, Making a Difference (MAD) were instrumental in the creation of the service and provide positive feedback on the impact on the quality of life for the children and young people who receive the support.

3.16 The arrangements for children with complex health care needs to transfer into secondary education are significantly enhanced through the work of the health advisor. The health advisor is funded and employed by Doncaster & Bassetlaw Hospitals NHS Foundation Trust and works for the Doncaster Children and Families Service. The role is to support health needs within education, through supporting and training teachers and other support staff in specific health interventions. This facilitates children and young people to access a full curriculum. There are appropriate arrangements for young people to transfer into adult services and the speech and language therapy services currently prepare a communication passport for use by the young person.

3.17 The provision of advice to young people on sex and relationships (SRE) is adequate. SRE is primarily delivered as part of the Healthy Schools programme through the PHSE curriculum. Delivery of SRE across all schools in Doncaster is variable. A recent consultation with young people on SRE concluded that the current provision of SRE does not meet their needs. The Contraception, Advice and Sexual Health (CASH) team provide good support to three secondary schools through a one stop advice clinic. These sessions provide advice, support for sexual health issues as well as prescribing contraception and are well attended.

3.18 There is good availability of emergency contraception, though the service is not well publicised to young people. There is good uptake of long acting reversible contraceptives and an effective Prevention of Second Pregnancy Programme to help young people avoid unwanted pregnancies. There has been some recent success in reducing the incidence of teenage pregnancy with rates of 51.9 per 1000 age 15 – 17 for 2009 which is significant decrease from the 2008 figure of 68.6 per 1000. There is now a 30% decrease in the incidence of teenage pregnancy since 2008. The CASH offer an outreach service to young people who are hard to engage in order to provide contraceptive services as well as support to enable them to access universal provision. CASH have made good attempts to target young people through partnership working and offer outreach support to established post natal clinics in children's centres and at new mums' meetings.

3.19 Young people have good access to drug and alcohol services. The Better Deal team offer specialist treatment for young people who abuse drugs and alcohol. The Better Deal team also provide advice and training to universal services as well as offering support to parents and carers. The service has an open referral system and accepts referrals from young people, their families or carers or professionals, as long as the young person has given their consent. All referrals are considered at a weekly team meeting and there are no waits for treatment. The service is well regarded with high numbers of young people completing their treatment plan.

3.20 The arrangements to ensure that children and young people coming into care receive a comprehensive assessment of their health needs which is used to develop a personal health plan are inadequate overall. The local authority's looked after children's team arrange for a general practitioner to carry out an initial medical assessment of the child or young person. A second initial health assessment is carried at around the same time by either a health visitor or school nurse. It is from the second assessment that a personal health plan is developed, often without sight of the medical assessment. There were some files inspected by CQC that did not contain a copy of an initial health assessment carried out by a registered medical health practitioner. A new pathway has been developed to address these concerns and is due to be implemented from April 2011.

3.21 The health visitor prepares the personal health plans and carries out all the review health assessments for LAC under 5 years and the school nurse for those over 5 years. The specialist LAC nurse or the clinical nurse carry out the review health assessments for those children and young people who are not in education or where there are special circumstances. All health visitors and school nurses are trained in the LAC initial and review health assessment process by either the specialist LAC nurse or the clinical nurse.

3.22 Eighty one percent of looked after children and young people are up to date with their immunisation and vaccination programme which is line with national performance for 2009, but only 65.7% have received a dental check within the previous year compared to 86% nationally for 2009 and only 44.4% received their initial health assessment within 28 days of coming into care.

3.23 There are no systems in place to routinely quality assure the health assessments or personal health plans for LAC in Doncaster or placed by Doncaster LA in other parts of the country. The initial health assessments, review health assessments and personal health plans scrutinised as part of the inspection were of variable quality, with some plans being incomplete.

3.24 Health partners are represented on the multi agency resource panel that agrees funding for the placement of children and young people. However the opportunity for health practitioners to influence the quality and appropriateness of a placement is variable. This had been an issue in the placement of some children in therapeutic environments where the CAMHS specialist nurses for looked after children had not been given the opportunity to comment on the suitability of the provision.

3.25 There is no consistent approach to identify that the status of children and young people who are looked after is recorded on their primary health record or on the GP's electronic health record.

3.26 Young people who are looked after can access the Bridge if they require support around drug or alcohol abuse. The school nurses do not use the drug and alcohol misuse screening tool routinely with age appropriate young people. There was some confusion as to whether school nurses had been trained in the use of the screening tool.

3.27 The arrangements for young people who are looked after to access contraception and sexual health are adequate. Although the young people can access universal provision, many of the school nurses have training in family planning and there is good support from the CASH outreach workers. There are, however, no specialist care pathways for looked after children for either substance misuse or sexual health services.

3.28 Access to CAMHS for looked after children and young people are adequate. The current arrangements are that any looked after child or young person who may require mental health services are referred to the CAMHS central point of access. The referral is then picked up by one of the senior specialist mental health practitioners. Initially the specialist mental health practitioners will offer consultation to any professionals or carers involved with the child or young person. If an appointment is necessary, then the senior specialist mental health practitioners will carry out an assessment and then determine the most appropriate intervention which can range from therapeutic work by the practitioner or referral on to colleagues for more specialist therapy. Until recently, the specialist mental health practitioners have been able to meet demand for their service, however, with the recent change in upper age limit of 16 to 19 they are now at capacity and new referrals will be placed on a waiting list.

3.29 There is good involvement of the clinical nurse in producing comprehensive health needs assessments for pathway plans for young people. However, young people are not currently provided with a comprehensive summary of their health record when they leave care.

4. Outcome 6 Co-operating with others

4.1 The arrangements in place to safeguard children and young people who attend A&E at Doncaster Royal Infirmary are inadequate. Although practitioners report that they check each attendance at the A&E department for any repeat attendance and that the NICE guidance on assessing safeguarding on the under 5's is common practice, this is not formally recorded. At the time of the inspection, the A&E staff could not directly establish if a child or young person had a child protection plan, however, this was remedied during the course of the inspection. There is no formal, documented process in place to identify if there is any social work involvement in the family or if the child or young person who is seeking care is looked after. This means that social workers and the specialist LAC nurse may not be aware of a child or young person's attendance. There are no processes in place to identify who has the legal capacity to consent to treatment for a child who is looked after or who the information can be shared with. A&E staff were confident in how to refer safeguarding concerns to the children assessment team and the named nurse received copies of all referrals for audit. During the course of the two week inspection, the trust responded to the concerns raised and have produced an action plan to address these findings. This action plan has been shared with the local CQC inspector.

4.2 There is good use of paediatric liaison through the Paediatric Liaison Health Visitor (PLHV). The PLHV reviews all attendances at A&E by a child or young person. As part of the review, she will consider the appropriateness of any safeguarding action taken and where necessary follow this up with A&E staff and the health visitor or school nurse.

4.3 There are adequate care pathways in place to support young people who attend A&E that require CAMHS following an incident of self harm or who are in mental health crises. Any young person under 16 is automatically admitted to the paediatric assessment unit for assessment by the CAMHS duty team during working hours or the crisis resolution team out of hours. It was reported that there is no Consultant Child Psychiatrist rota to provide advice and support to A&E or the adult crises resolution team out of hours.

4.4 Historically, there has been no direct support for young people who attended A&E where drugs or alcohol was identified as a contributing cause for seeking treatment. Better Deal and A&E are in the early stages of developing a pilot project to support A&E staff using a screening tool for substance misuse and combining this with assertive follow up where young people have given their consent. The project is scheduled to start in June 2011.

4.5 Staff in A&E were able to demonstrate good awareness on the impact of domestic violence between adults on children and confirmed that when domestic violence had been disclosed during an A&E consultation, if there were children in the home then a referral to the children assessment team was made. However, staff working in the 8-8 Walk in Centre operated a different policy and would negotiate the parent's agreement before any referral. This is not compliant with local policy on domestic violence.

4.6 There is a shared multi agency escalation policy to resolve professional disagreements about decisions reached on child protection and child in need cases. The policy is effective and used well within RDaSH and Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

4.7 There are improved processes in place to identify where service users have children or have significant child caring responsibilities in both adult mental health services and adult substance misuse services. Staff have received training and briefings on the need to regularly risk assess the impact of the service user's mental health on the safety of the children and escalate where appropriate.

4.8 The partnership arrangements to safeguard the unborn child had lapsed. Actions between health and social care professionals have been agreed very recently to ensure that formal and routine conferences are held monthly to ensure the creation of timely and multi disciplinary discharge plans and the need for any formal intervention to protect the unborn baby although it is too early to determine impact.

4.9 The integrated family health teams have good arrangements to safeguard children and young people. Good use is made of skill mix within teams and there is increased working as part of CAF and team around the child, though numbers of CAF remain of concern. Nursery nurses and family support workers carry out specific programmes of work with families as part of a child protection plan under the supervision of the health visitor, for example behaviour management, keeping safe, sleep programmes, nutrition and weaning.

4.10 There is good partnership working to ensure that where possible families are protected from domestic violence. Health partners are well represented on the local MARAC. There is effective multi agency assessment of police notifications following attendance at domestic violence incidents where children were present through the "Blue" meetings.

4.11 Health partners use the CP1 form as the referral to children and families. The form has recently been revised to provide more detail as well as strengthening the content of the analysis of risk to the child or young person. The agreed process is for any urgent referral to be discussed with the local authority's children assessment team and then a completed CP1 form to be faxed across within 24 hours.

4.12 Some health practitioners expressed their frustration with the effectiveness of core groups. There are issues around health practitioners, including general practitioners, regularly attending child protection meetings and this is being monitored.

4.13 The Specialist LAC nurse has been involved in training of foster carers in health promotion and there has been good involvement of the clinical nurse with the local children's homes. The CAMHS mental health workers also provide a drop-in service for advice and support to residential staff in the children's homes and this was described as valuable by workers, however foster carers are unable to access support and advice from this service.

5. Outcome 7 Safeguarding

5.1 The arrangements for the Child Death Overview Panel are adequate. The panel is properly constituted and is supported by the partnership. Attendance of members is good. The rapid response arrangements are reported to be working well. The report for 2009/2010 is however significantly delayed and at the time of the inspection is still in draft.

5.2 The current arrangements in place for the designated nurse and interim designated doctor are adequate. The interim arrangements have been agreed in order to maintain professional leadership necessary for the health economy. Alternative models of safeguarding leadership are being explored across South Yorkshire & Bassetlaw as part of the PCT cluster.

5.3 Doncaster PCT offer good support to primary care. The safeguarding local enhance service (LES) is a good example of taking forward the recommendations from a serious case review on the need to improve communication in primary care. The GP practices that have opted into the LES meet with a named health visitor on a formal basis to discuss cases where there are concerns around the safety of a child. The GPs, health visitors and school nurses interviewed during the inspection were positive about the benefits of the LES and the impact of the meetings in ensuring a co-ordinated approach to the care of these families. There are regular opportunities for general practitioners to attend safeguarding training and the PCT offer ongoing encouragement and support to GP practices to enable them to fulfil their responsibilities under Working Together 2010.

5.4 The named safeguarding professionals for Doncaster Community Healthcare offer adequate support to practitioners working for the trust. There are three named nurses in post that are aligned to specific geographical teams across Doncaster and who have different lead safeguarding responsibilities. The named nurses are copied in to all referrals made to children and families as well as any reports prepared for child protection conferences and use this information to inform safeguarding supervision sessions. The named nurses offer support to newly qualified health visitors and school nurses, with a minimum of monthly safeguarding children supervision provided until a practitioner can demonstrate confidence and competency. The named doctor for the trust is currently acting as the designated doctor for the PCT. The current arrangements do not comply with the requirement for the named nurses to work closely with the trust board executive lead for children safeguarding as described in Working Together 2010 as the named nurses do not meet regularly with the trust board executive lead. However, the Doncaster Community Healthcare transferred into the RDaSH NHS FT on the last day of inspection and will be part of new management arrangements.

5.5 There is no designated doctor for the LAC service. This has been an unfilled vacancy for an unacceptable length of time. The specialist LAC nurse is new into post and is employed full time. She is assisted in her work by a Band 5 clinical nurse who is employed for 0.6WTE. There are good links with the children's residential homes in Doncaster. The LAC health team are in the process of transfer to RDaSH NHS FT as part of the transforming community services agenda and will become part of the trust's safeguarding unit.

5.6 The named safeguarding children professionals for Doncaster & Bassetlaw Hospitals NHS Foundation Trust are appropriately line managed and well supported. There is good and effective access to the trust executive board lead for children safeguarding. The named nurse for safeguarding children is the safeguarding team leader and is supported in her work by a specialist nurse employed for 0.8WTE. The named doctor has 2 PAs allocated to the role (ten hours). The named midwife is also the manager for community midwifery. The job description for the post of named midwife is still in draft. The trust has a lead paediatric anaesthetist for child protection/safeguarding who undertakes the role as set out in the Royal College of Anaesthetists guidance and referenced in the intercollegiate guidance

5.7 The arrangements for the named professionals within RDaSH are appropriate and effective. The named nurse is one of three named nurses employed by the trust all of whom have specific area responsibilities to coincide with the local safeguarding boards. The named nurse for Doncaster is employed full time and is line managed by the Deputy Director of Nursing Services but reports to the trust board lead for safeguarding children, the Deputy Chief Executive. The named doctor is also the medical director for trust, though this will be reconsidered as the trust expands and incorporates community health services as part of the transforming community services agenda.

5.8 Following a previous multi agency audit on selected child protection cases, the named nurse for RDaSH produced a template for all child protection reports with guidance on completion. Use of the template has produced a significant improvement in the overall content and quality of the reports submitted for child protection conferences. The named nurse is copied in to all referrals to children and families and receives a copy of any reports prepared for conference.

5.9 The current pathways for the referral of children who have suffered suspected sexual abuse are inadequate and do not meet the needs of children. The arrangement for follow up care of those children who are initially examined out of the area and require follow up from the local paediatric service is fragmented. Children aged 13 and over follow the adult pathway and are examined by the forensic police surgeon without paediatric support. The problems associated with this service are known to PCT commissioners who are working with the specialist clinical network to collaboratively commission a new care pathway *(Ofsted May 2011)*

6. Outcome 13 Staffing numbers

6.1 The A&E at Doncaster Royal Infirmary is unable to roster a nurse who has been trained in paediatrics to cover all shifts. However, most staff have been trained in either intermediate or advanced paediatric life support and there is good support from paediatricians and the paediatric ward on site.

6.2 There is some concern around the capacity of the community children's nursing team. The establishment for the team is 3.2WTE to provide a 7 day service, however, there are only 1.8WTE staff in post. This has implications for children and young people who receive care from this team as work will often have to be prioritised.

7. Outcome 14 Staffing support

7.1 There is good provision and uptake of safeguarding children training within DCH. Any new staff taking up a post within the integrated family health teams has a period of induction and work within a newly introduced competency framework. There are effective arrangements in place to ensure that DCH practitioners who are working with children and young people who have a child protection in place, or identified as a child in need receive regular timetabled and formal children safeguarding supervision. Uptake of children safeguarding supervision shows continuous and sustained improvement.

7.2 Doncaster & Bassetlaw Hospitals NHS Foundation Trust have made good progress in ensuring that staff that work predominantly with children have been trained appropriately. The named nurse has recently completed a training needs analysis that is now being used by all the clinical service units across the trust to identify which staff will require additional training. The named nurse has revised the trust's safeguarding children supervision policy. Arrangements have been made for 45 staff to receive safeguarding children supervision training to support the implementation of the policy.

7.3 Rotherham, Doncaster and South Humber NHS Foundation Trust has a comprehensive training needs analysis that clearly identifies their training requirements in safeguarding children for all roles within the trust. This means that they will be able to accurately report on the numbers of staff who have received the appropriate safeguarding children training. The current arrangements for safeguarding children supervision does not ensure that all staff receive safeguarding children supervision on a formal timetabled basis from appropriately trained staff. The trust are in the final stages of revising their safeguarding children supervision training to address the current deficiencies and to reconcile practice with the overarching safeguarding children supervision policy for all Doncaster health providers.

8. Outcome 16 Audit and monitoring

8.1 Doncaster PCT has good arrangements in place to monitor safeguarding children practice through the safeguarding assurance forum. Up until very recently provider trusts have been required to submit monthly reports, though this is now moving to quarterly reporting against the individual trust's annual declaration. There will continue to be exception reporting.

8.2 The PCT has been effective in influencing good practice in safeguarding children within provider services through the effective use of Commissioning for Quality and Innovation (CQUIN) targets and other key performance indicators. A recent root cause analysis of serious case reviews has been used to effectively influence good safeguarding children practice.

8.3 Doncaster Community Healthcare transferred to RDASH on 1 April 2011 as part of the transforming community services agenda. Prior to the move, there were established and effective arrangements in place to provide assurance to the PCT Trust Board on safeguarding children.

8.4 There are appropriate arrangements in place to provide RDaSH with effective board assurance on safeguarding children. The governance arrangements are through the safeguarding strategic forum which is a formal sub committee of the trust board and is chaired by the board lead for safeguarding. The trust's operational safeguarding forum meets monthly and is attended by the named professionals as well as operational managers for all directorates. The operational safeguarding forum sets and monitors the annual safeguarding work plan, as well as monitoring actions arising from any serious case reviews, management reviews or any local or national initiatives. The named nurse submits exception reports and updates to the strategic safeguarding forum through the monthly reports that are prepared for the operational safeguarding forum.

8.5 Rotherham, Doncaster and South Humber NHS Foundation Trust has a programme of audit to monitor safeguarding practices within the trust. The named nurse produced a comprehensive baseline audit tool to examine internal record keeping. The audit report found that there were improvements required around recording practices and that the trust's IT system did not facilitate easy identification of safeguarding risks and activity. A comprehensive action plan was produced and good progress is being made, with the named nurse now in the final stages of agreeing revisions to the trust's IT record.

8.6 The governance arrangements and board assurance for children safeguarding in Doncaster & Bassetlaw Hospitals NHS Foundation are adequate. The trust has a strategic safeguarding people board that is chaired by the trust board executive safeguarding lead, currently the director of nursing. The strategic safeguarding children board monitors and sets the work of the operational safeguarding group. The operational safeguarding group is attended by a representative from each clinical service unit. The group set and monitor the safeguarding children work plan, consider progress against action plans arising from serious case reviews, individual management reviews and any national or local recommendations.

8.7 The Doncaster & Bassetlaw Hospitals NHS Foundation Trust has a programme of audit to monitor compliance with safeguarding children trust policy. The trust has a Did Not Attend (DNA) policy to ensure that children and young people are not discharged from the service following any non attendance without the decision being reviewed by a clinician and due consideration given around any safeguarding concerns. Compliance with this policy has not yet been audited and there were concerns expressed during the inspection that some children and young people were being discharged inappropriately.

9. Recommendations

Immediately

- *improve attendance by the Police and health professionals at child protection conferences. (Ofsted, May 2011)*
- *take urgent steps to appoint a designated doctor for Looked After Children. (Ofsted, May 2011)*
- *ensure all children and young people have an initial health assessment on entering the care system. (Ofsted, May 2011)*
- *ensure that the framework for the health and wellbeing of looked after children is implemented without dela. (Ofsted, May 2011)*
- ensure that all NHS commissioned services adhere to local protocols on reporting and responding to incidents of domestic violence.

Within 3 months (from report)

- *improve the quality of sex and relationship education for all children and young people. (Ofsted, May 2011)*
- *develop effective care pathways for children with Attention Deficit Hyperactivity Disorder (ADHD) to ensure coordinated and timely assessment, diagnosis and treatment. (Ofsted, May 2011)*
- *provide sensitive clinical services and good follow up care for children alleged to have been victims of child sexual abuse. (Ofsted, May 2011)*
- *improve completion rate of Common Assessment Frameworks (CAFs) (Ofsted, May 2011).*
- *the LAC health nurses must provide young people leaving care with a comprehensive summary of their healthcare. (Ofsted, May 2011)*
- Ensure compliance with the overarching Doncaster Guidance on Safeguarding Children Supervision for all NHS provider services.
- Review the capacity of the community children's nursing service to ensure that it can meet demand without compromising patient care.
- Develop effective care pathways for children with learning disabilities and ensure that they have they have timely access to a specialist consultant.
- Review the care pathway for looked after children that are referred for mental health support to ensure that they are not adversely impacted by the resources of the specialist mental health workers.
- Review the arrangements for out of hours support from a consultant child psychiatrist to A&E and the adult crises team.
- Agree a common approach to recording the status of looked after children and young people on their primary medical record.

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 the CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.