Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children’s Services in Derbyshire

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<tr>
<th>Date of Inspection</th>
<th>7th March – 18th March 2011</th>
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<td>Date of final Report</td>
<td>6th May 2011</td>
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<td>Commissioning PCT</td>
<td>NHS Derbyshire County</td>
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<td>CQC Inspector name</td>
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<tr>
<td>Provider Services Included:</td>
<td>Chesterfield Royal NHS Foundation Trust; Derbyshire Community Health Services; Derbyshire Healthcare NHS Foundation Trust</td>
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<td>CQC Region</td>
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<td>CQC Regional Director</td>
<td>Dr Andrea Gordon</td>
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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.

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<th>Derbyshire County Council</th>
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<td><strong>Safeguarding Inspection Outcome</strong></td>
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<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Good</td>
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<td>Capacity for improvement</td>
<td>Good</td>
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<td>Contribution of health agencies to keeping children and young people safe</td>
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<th><strong>Looked After children Inspection Outcome</strong></th>
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<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
<td>Good</td>
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<td>Capacity for improvement of the council and its partners</td>
<td>Good</td>
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<tr>
<td>Being Healthy</td>
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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 and Monitor as appropriate and CQC’s Head of Statutory Inspections and Mental Health Operations who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week 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:

Derbyshire is a large, mainly rural county of moors, hills, small villages and busy towns. Levels of affluence and deprivation vary across the county. The overall population is now around 764,000 of whom 175,400, 23.2%, are aged between 0-19 years old. The minority ethnic population is small at 2.98%. However, children and young people from minority ethnic groups account for 4.7% of pupils in primary schools and 3.8% of pupils in secondary schools. This is below the national averages of 25.7% for primary schools and 22% for secondary schools. More recently small numbers of people from Eastern Europe have begun to settle in the north east of the county.

The Derbyshire Children and Young People’s Local Strategic partnership was set up in 2002 and the Children’s trust established in 2006. The Trust includes representatives of NHS Derbyshire County, NHS Tameside and Glossop, Derbyshire Police Authority, Derbyshire Fire and Rescue Service, Connexions, community and voluntary organisations, schools and the further education sector.

Specialist services for children with disabilities are provided by four specialist teams and two paediatric social care occupational therapy teams. Other preventative services are delivered by 54 designated children’s centres situated across Derbyshire.

At the time of the inspection 632 children and young people were looked after by Derbyshire County Council. They comprise of 163 children under the age of five, 408 children of school age (5-16) and 61 young people aged 17.

Commissioning and planning of health services for children are carried out by NHS Derbyshire County. “There is a joint commissioning appointment between the Primary Care Trust (PCT) and local authority and a jointly appointed Deputy Director of Public Health to develop consistency of children’s services across health and social care agencies. Acute hospital services are provided by Chesterfield Royal Hospital NHS Foundation Trust (CRHNHSFT) and Royal Derby Hospitals (RDNHSFT). Occupational therapy and speech and language services are provided by NHS Derby City, Chesterfield Royal Hospital NHS Foundation Trust and Derbyshire Community Health Services (DCHS). NHS Tameside and Glossop are responsible for the planning and commissioning of children’s services in Glossop. Community based services are provided primarily by Derbyshire Community Health Services and Chesterfield Royal Hospital NHS Foundation Trust. Universal, targeted and specialist Child and Adolescent Mental Health Services (CAMHS) are jointly commissioned by NHS Derbyshire County and the local authority. Specialist CAMHS are provided by Chesterfield Royal NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust (DHNHSFT) with some targeted emotional well-being provision for looked after children provided by the local authority. There is no age appropriate mental health in-patient accommodation for children or young people who require specialist care in Derbyshire. (Ofsted, April 2011)
1 General – leadership and management

1.1 The PCT is an active member of the Derbyshire Safeguarding Children’s Board and Children’s Trust. The joint strategic needs assessment is used well to target interventions to address health inequalities within the county. A new pooled budget ensures needs based services for children with complex health needs and there is good use of aligned budgets, for example for the teenage pregnancy and prevention and substance misuse services which achieve good outcomes against these local priorities.

1.2 Ambition and prioritisation are good. There is a clear understanding of the national context for the delivery of children’s services and of Derbyshire’s position within that context. The importance of safeguarding children and young people is recognised at both strategic and operational levels across statutory, voluntary and community organisations. Operational staff demonstrate a very clear and robust child-centred commitment and approach to their work with children and young people.

1.3 The Children and Young People’s Plan (CYPP) is based on a robust needs analysis and clearly articulates appropriate priorities that underpin multi-agency practice. The ambitions and priorities set out in the CYPP are implemented and monitored by the Children’s Trust Board and the DSCB. There are strong links between the council’s corporate plan and cross-directorate service plans. Translating priorities into action is clearly evidenced by the partnership through the investment to develop and expand preventative services, such as the MATs to further improve outcomes for children and young people.

1.4 There is good cross-party political support from elected members for children’s services with a clear political consensus that services to children and young people are a priority that must be appropriately resourced. The lead member for CAYA supported by the portfolio holder for education takes a strong and active interest in the performance of services for children, young people and their families. The role of scrutiny is well understood and the committee is actively engaged in the children’s agenda. It receives regular reports on aspects of the service’s provision, interviews CAYA senior managers and it commissions specific work as appropriate. (Ofsted 2011)

1.5 NHS Derbyshire County and other healthcare organisations in the county have developed and implemented adequate governance and accountability systems.

1.6 All healthcare organisations have up to date research based safeguarding policies and procedures in place with some audit arrangements. However, the commissioning Trust recognises that the implementation of these policies and procedures needs more robust and regular auditing to provide adequate assurance that staff understand and are following them.

1.7 Effective information sharing remains a challenge for all health partners in Derbyshire as a result of disparate systems throughout the county. There remain some unresolved issues in respect of professional boundaries, in particular, the barriers to effectively sharing information between professionals in child and adult mental health services and partner agencies, and which have an impact on outcomes for children and their families.
1.8 Commissioning arrangements for the health care of looked after children living out of Derbyshire are adequate. Named nurses retain registers of children and trigger annual health assessments.

1.9 Service delivery and organisational differences across and between health providers’ impact adversely on equity of service, effectiveness and robust performance management. Arrangements for named and designated professionals are not fully in line with national guidance. Some named practitioners roles are delivered through shared appointments. Particularly in the Chesterfield and north east area where the named doctor role is covered by a patchwork of individuals, this further impacts on the effectiveness of the full role. Given the complexity of provision county-wide, the absence of a designated nurse for looked after children has also negatively impacted on the co-ordination and achievement of quality arrangements across the county.

1.10 Partnership work between key agencies is variable. Healthcare professionals interviewed gave examples of excellent partnership working in places and some inadequate arrangements notably mentioned in relation to adult mental health services and the CAMH services, as well as the need to ensure countywide strengthening of partnership working with social care staff in children and families teams.

1.11 Partnership arrangements for conducting serious cases reviews are in place and have helped to drive some important changes but are not fully effective. Delays have occurred in completing recent IMR reports and the completion of action plans from previous serious case reviews. This has largely been a result of difficulty in securing the agreed contributions from the DHNHSFT and the partnership needs to strengthen arrangements to ensure timeliness and the ongoing full engagement of all partners.

2 Outcome 1 Involving Users

2.1 There is little evidence of the systematic involvement of young people in the strategic planning of health services in Derbyshire. Consultation had been used in designing some changes, for instance to the CRHNHSFT midwifery service and in establishing the safe sleeping assessment where mothers were consulted about the idea of physically checking sleeping arrangements. However, surveys and consultations are not widely and systematically used by health partners.

2.2 Parents of children with disabilities have a ‘real’ voice in the planning of services through the growing membership of a county wide network of parent forums. Investment in the successful and highly valued Aiming High short breaks programme for children with complex needs and their families was directly informed by their views. There was excellent information about the new, fully equipped holiday lodge that was about to open to offer breaks to these children and their families. Parents of children with disabilities generally had good access to a range of equipment to help meet their children’s needs.
2.3 However, parents of children with disabilities had generally found it difficult to access information about the opportunities or service pathways available to them and their children. There remained a strong reliance on networking with other parents as the most effective source of signposting. Once in touch with the right services, many people were very satisfied with the help they received. Professionals lack a consistent approach to the giving of timely information at key transition times. Parents of young people who had embarked on the transition from children’s services remained unclear about the pathway and the options that would be available.

2.4 Good attention is paid by NHS Derbyshire County PCT to ensure that equality and diversity issues are part of everyday practice despite the largely white British profile of the population. Health agencies have robust policies and procedures to ensure translation and interpretation is provided promptly where needed for hospital and community staff. The service is used by staff on a regular basis and all staff spoken to knew how to and had accessed interpreting services.

2.5 There is a good system to ensure that all looked after children have a named nurse to co-ordinate their annual health assessments and provide on going advice according to their needs and wishes. Scrutiny of health files during the inspection showed that the child’s preferences and needs are taken into account including choice of location for the annual health review.

3 Outcome 4 Care and welfare of people who use services

3.1 Outcomes for the health of all children and young people across the county are generally good. The teenage pregnancy strategy has achieved marked success, with rates of teenage pregnancy low overall and having fallen more rapidly than seen regionally or nationally. In Bolsover district however, teenage conception rates remained much higher than elsewhere and interventions have been less effective. Obesity at the age of five has increased to be slightly worse than national and regional averages, and at 11 is average, with trends increasing. Initial and six week breastfeeding rates are below targets.

The joint strategic needs assessment clearly identifies the impact of deprivation on children and young people’s well being; health inequalities across Derbyshire have resulted in very different and much poorer outcomes reported in the most deprived wards.

3.2 Provision of sex and relationship education and advice is good. The service provides contraceptive and sexual health services (CASH) and is now starting to roll out the C Card initiative, jointly with youth workers. The service was in the process of change away from sexual health outreach work to fixed clinic arrangements and some concern whether this impact on outcomes. There is good access to contraceptive services seven days a week across the county through a number of providers and based in settings as diverse as youth centres, enhanced level GP practices, Youth Offending Service (YOS), drop in sessions in colleges of further education, some secondary schools, urgent care settings and pharmacies. In addition, young people have good access to contraceptive implants, oral contraception and emergency contraception through trained pharmacists and the four minor injuries units. Given the size of the county and transport difficulties for young people, there are still some challenges to ensure services are accessible to young people in rural areas.
3.3 Partners are using data on conception rates well and are now targeting identified courses at local colleges where the young people have had a higher risk of unplanned conception and are providing additional resources onto these courses. It is too early to measure the impact of this.

3.4 The good, targeted health promotion activities for looked after children, with support from sexual health and prevention services, has resulted in low numbers of pregnancies of young teenagers in care. Health professionals offer targeted advice to individuals and groups of looked after young people, for example Baby Think Twice, a course of advice and understanding about the impact of motherhood. Feedback showed that young people who took part valued the learning and support.

3.5 Teenage parents are fairly well supported; the development and implementation of clear pathways for pregnant teenage parents and pregnant looked after children have contributed to an adequate level of care for this vulnerable group. Teenage mothers receive good help to continue with their education. However, work with young fathers in universal settings is at an early stage and too early to measure impact, though support is offered through children’s centres or in Action for Children aftercare services. There is a specific clinic for teenagers who are pregnant but there is no specialist midwife, the work previously done through Connexions has not been continued and social care withdrew from the arrangements. Enquiries about fathers and their other children are systematically made. Young parents receive targeted, intensive support to care for their baby from health, social care and education services. Multi-agency care pathways have contributed well to the integrated care provided to young parents. Young fathers have been successfully targeted to increase their level of involvement with their child, children’s centres through good individualised support.

3.6 The midwifery service provides good support through effective systems to identify and safeguard vulnerable mothers and their babies. Booking systems identify risks which are then monitored and addressed through targeted services. Specialist clinics are provided, a specialist midwife runs a dedicated clinic for mothers with substance misuse issues, supported by a specialist GP, social worker and other professionals. The Healthy Child Programme starts in midwifery where midwives use the standard booking tool and a mental health screening tool when booking pregnant women. The booking forms and screening tools have prompts to address emotional health and wellbeing issues, including domestic violence. Any concerns are then are escalated according to the organisation’s protocol.
3.7 The provision of health visiting across Derbyshire is adequate. The Healthy Child Programme for children 0-5 years is fully delivered and some teams offer an additional visit at 3-4 months. The health visiting teams carry out an initial antenatal visit and then targeted risk assessed ante natal visits as often as weekly if required. All health visitor teams have been trained to deliver the Health Exercise Nutrition for the Really Young (HENRY) programme to all families irrespective of need before a child is six months old. However, capacity to deliver the full range of services to young children and their families is not yet in place across the county due to the variable capacity and skills mix of health visiting teams. The distribution of services is not yet targeted to ensure the full range of support is available to the most vulnerable children. Some recent case load analysis has started to address the historically inequitable arrangements across teams where case loads still vary between 50 and 100 per day and have not yet been targeted to areas of greatest need.

3.8 School nurses offer a good service, working in effective partnerships with a range of professionals to reach young people and using a targeted approach in areas where young people are especially vulnerable. School nurses work hard to overcome barriers to ensuring vulnerable young people have access to their support and in enhanced education and advice programmes. However, pressures on resources result in frequent periods when their involvement is cut back to the minimum, resulting in loss of impetus in their engagement with individuals and groups.

3.9 Most children with disabilities and their families received a good service from staff working in specialist teams. A few families related less satisfactory experiences and found it difficult to access timely information and services especially where children were in mainstream schooling. There were examples of holistic assessment and planning recognising the needs of the whole family. However, parents had not been engaged in contingency and emergency planning and this was also lacking from the records within the files we examined. None of the parents we met was aware of, or part of a carers’ emergency card scheme, a government initiative to ensure carers can be easily recognised in the event of an emergency and that back up support is in place.

3.10 Overall service arrangements for CAMHS are inadequate due to the inequitable provision of timely services for children in the county. Service review has been a priority for some time and some progress is evidenced in the recent new CAMHS learning disability teams. Access to primary level CAMHS or social care CAMHS support is variable. Inconsistency, resultant from ongoing service changes and vacancies which challenge capacity, has reduced direct work with children. Average waiting times to access CAMHS tier 3 assessments provided in the south, through DHNHSFT, are twelve weeks, and in the north, through CRHNHSFT, are on average seven weeks. In both areas this is worse than the national average performance of six weeks. In the north children also waited six to eight months for a clinical psychologist appointment. The impact of this was worsened by unclear pathways and thresholds which can result in initial inappropriate referrals to other professionals who then have to refer onto the psychology waiting list.
3.11 Arrangements for looked after children to access specialist health therapies such as CAMHS, speech and language therapy, physiotherapy and psychology are not consistent or adequate to ensure speedy access. In different areas of the county there are variable access pathways, service patterns and waiting times for these specialist health services. Although any urgent referral is considered, there is no fast track service for looked after children.

3.12 The reduced availability of dedicated CAMHS workers for looked after children has made it harder to ensure vulnerable children get help when they need it. Though the service continues to support and provide training to foster carers around emotional and behavioural difficulties, direct work with children is limited. The use of the strengths and difficulties questionnaire (SDQ) has also altered as a result of staffing pressures in CAMHS, and was reported to be less effective and lacking in follow up resources to meet needs it identified.

3.13 Outcomes for looked after children, young people and care leavers are mostly good and well supported by multi disciplinary health teams provided by CRHNHSFT in the north and by DCHS in the south. Named nurses have access to the county’s social care IT system and are also able to access all health records for looked after children in the county. Each child has a named nurse who informs and works with the school nurse as soon as a child comes into care. They effectively engage with children and co-ordinate their support, working closely sexual health, substance misuse, youth offending services and with school nurses. Named nurses and school nurses report inconsistent arrangements dependent on individual independent reviewing officers to inform or invite them to looked after children reviews or provide copies, even when the children have health needs about which the named nurse could contribute.

3.14 The completion of annual health checks is good at 93%. This is a slight decrease on performance in 2008-09 but compares well with similar authorities. The timeliness of initial health assessments is variable, in the main due to cross-provider communications issues. There are significant differences in the way initial health assessments are carried out with GPs commissioned in the north and paediatricians in the south. Review health assessments are done by a range of professionals including paediatric staff, GPs and named nurses. These arrangements lead to significant variability in the quality and detail of assessments and health plans. Consequently, monitoring arrangements are variable, some overview of the health of looked after children and young people is provided by the children in care strategy group but there was no evidence that overall trends or themes were readily identified. Young people leaving care are not supported in looking after their ongoing health through awareness of their health history. There are no arrangements to provide them with any of their health history for their time in care or records other than their immunisation record.

3.15 Access to dentistry and other general health services is very good, 98% of looked after children accessed annual dental checks, well above similar authorities. However, arrangements have become less effective in ensuring immunisations.
3.16 The drug and alcohol service in Derbyshire is good. Looked after children and care leavers have access to dedicated workers from the SMASH team (substance misuse and sexual health services). Tier 2 services had been effectively provided by Connexions but in the process of change, new arrangements were as yet unknown to partners. CRHNHSFT provides an effective tier 3 substance misuse service in the north of the county which works with other agencies and achieves good outcomes for young people, achieving high rates of continued engagement in treatment programmes. The arrangement is mirrored by DHNHSFT in the south of the county.

4 Outcome 6 Co-operating with others

4.1 Complete or part time co-located working arrangements between partner agencies are increasing, though patterns are variable around the county. Where implemented co location was helping to deliver more integrated care and improved understanding and information sharing between health disciplines and with social care teams. Some previous communication routes that had been altered by location changes were still being worked through. The impact of the location move of the northern CAMHS from co-location with social care staff to the Chesterfield Royal Hospital site had significantly altered communications networks especially in respect of effective relationships with children’s social care.

4.2 The quality of liaison between health partners and social workers in area teams is variable though generally improved and in some cases very effective. A range of health partners reported inconsistency of communication from social care teams which impacted on effective working as a team around the child. Health visitors attend social care team meetings and formalisation of these arrangements is being implemented. School nurses report much improved multi-agency working, though the school nurse role is not yet fully understood by all partners including some GPs and schools. Weekly paediatric liaison meetings at Chesterfield Royal Hospital are increasingly attended by social care staff. Arrangements for communication to and from CAMHS are variable and in some cases that lack of communication was a barrier to effective working with children and their families. CAMHS staff in CRHNHSFT likewise experienced differing levels of communication including inconsistent responsiveness from social care staff, although they reported good relationships with other agencies and regular meetings with schools. Staff changes in social care team management had reportedly impacted on their ability to meet with CAMHS professionals in the northern districts especially.

4.3 An information sharing protocol has been agreed across the partnership but some clinicians are not fully accepting or acting in accordance with the protocol. This failure to comply with the protocol has the potential to impact negatively on the effectiveness of risk assessment and planning. Senior managers within the PCT are aware of this issue and through its commissioning processes have recently taken action to strengthen expectations and commitment to child protection processes.
4.4 Health visitors, school nurses, community midwives and specialist nurses make a good contribution to safeguarding arrangements and other multi agency planning, making good use of the common assessment framework (CAF). They give priority to their contribution to conferences and plans through reports and where possible, attendance at meetings.

4.5 Health partners have a varied understanding of thresholds for making referrals to social care. Safeguarding lead nurses often play a significant and effective role in consultancy and liaison in their services and had an active role in escalating concerns to social care although there appeared to be no agreed county wide escalation policy. Arrangements are inadequate to ensure Social Care provides referrers with feedback about safeguarding referrals and this is a particular problem for the drug and alcohol service and CAMHS teams. Practitioners who made referrals did not always know the outcome of them.

4.6 Different service levels and unclear access pathways to CAMHS services are confusing to agencies making referrals and lead to different services depending on the route. To manage uncertainties about CAMHS thresholds and to assist looked after children to access services, the specialist nurse in the High Peak district had developed a screening tool which was helping community health staff to identify thresholds for CAMHS referrals and this was proving a positive resource.

4.7 Partnerships in arrangements for children with significant emotional needs are not satisfactory. Looked after children with complex emotional needs who need specialist help to be able to achieve placement stability lack an agreed and timely pathway to ensure they get the help they need. There are also unresolved issues in respect of children with attachment issues which are not assessed to be a mental health problem who can have difficulty in getting the clinical help they need in the absence of an agreed county-wide service pathway.

4.8 There is a limited out of hours CAMHS provision backed by an on call consultant. Out of hours, children and young people in the CRHNHSFT area who present with mental health needs are generally admitted to a paediatric ward to await assessment as CAMHS duty does not provide an out of hours assessment service within the hospital. The need for a number of specialist services has been identified as a result of serious case reviews and commissioning has started in some areas, for instance there are developing arrangements to care for young people under 16 who present with self harm or substance misuse. A specialist self harm and suicide service is in place in the north during core hours, based at Chesterfield Royal Hospital. Both Trusts are working to a draft protocol to admit under 16’s for assessment until the next day at least, and to offer 7 day follow up.

4.9 The arrangements for carrying out either an initial health assessment or health review for looked after children who are placed outside the county are adequate. When a child or young person is placed out of county, the looked after child health team contact their counterparts in the receiving area to confirm the process for the child or young person’s initial health assessment and annual health reviews. Specialist nurses track the flow of looked after children both in and out of the county and ensure access to reviews of their health needs through reciprocal arrangements. There is adequate communication from Derbyshire children’s social care services about notifications such as change of placement address though this is slower when children move across health boundaries.
4.10 A high number of looked after children are placed by other councils in independent placements in Derbyshire. The children and services that support them receive good support from Derbyshire’s specialist nurses for looked after children and the county’s primary health practitioners. The impact of the high numbers of these placements significantly increases the workload of professionals, for instance one nurse had a case load of 149 children plus children in a 36 place private residential service.

4.11 Good training helps foster carers support young people when discussing sexual health and wellbeing issues and to help signpost to appropriate services. Specialist nurses also offer advice on diet and obesity, support evenings and one to one support and contribute to the health module of foster carers CWDC training. Foster carers value the support they receive from a range of partners which contributes to maintaining the placement stability of looked after children.

4.12 There is good awareness and training around the link between domestic violence and the impact on the child. Midwifery staff, school nurses and health visitors received notifications of when the police had been called to an incident of domestic violence and triaged the notification according to protocol. Staff in the A&E department and the MIU were clear about the need to refer to social care’s child and family services if they treated an adult who had presented with injury following domestic violence or other risk taking behaviours. The contribution of health to multi-agency risk assessment conference (MARAC) and Multi Agency Public Protection Arrangements (MAPPA) to keeping children safe is good, with effective relationships and appropriate representation and involvement of named and designated professionals.

4.13 Most health professionals contribute well to child protection conferences and core group meetings either by attending or submitting reports. However unresolved difficulties in information sharing and some unreliable systems can impact on the effectiveness of risk assessment and planning. GPs attendance at conferences is infrequent and the provision of their reports inconsistent and an area identified for improvement. CAMHS staff attendance at conferences and provision of reports has also been patchy across both mental health trusts. The issue has been identified within the action plan from the review of services by DHNHSFT (south CAMH service) where the Board has recently restated and strengthened its expectations and commitment to child protection processes and they reported improvement.

5 Outcome 7 Safeguarding

5.1 There is good representation from all provider NHS trusts and NHS Derbyshire County on the DSCB and its sub-groups, with clear escalation routes through organisations’ governance structures. There is good evidence of dissemination of learning from serious case reviews.
5.2 The designated and named safeguarding leads give strong and effective leadership where their roles are embedded. However, there is a lack of consistency and caseload management within the designated and named health practitioners for safeguarding across the county. The designated safeguarding nurse for NHS Derbyshire County and the designated doctors who share leadership are actively involved in promoting learning through serious case reviews. The designated nurse is heavily involved in the design and delivery of training to health partners in partnership with DSCB. The named paediatrician role for the commissioning arm of NHS Derbyshire County had recently been extended to cover the three areas of South Derbyshire, High Peak and Amber Valley over 5 sessions, with the remainder of the named roles in the county covered by doctors each providing one session. The role of named GP is discharged differently by each Trust. There is no countywide named doctor for DCHS provider services and no designated nurse for looked after children. As a result, the services provided are not fulfilling their roles in line with national guidance and Royal College requirements.

5.3 GPs awareness of their responsibilities and involvement in safeguarding is improving and in some areas very good. A particularly good example of the value of active, named professionals is the strong progress that has been achieved in the Heanor district in the South, through universal and targeted GP training and sharing of information supported by an enthusiastic named GP working with named nurses. The work has been backed by a dedicated website to draw together relevant procedures and good practice in safeguarding children.

5.4 Designated professionals are respected and experienced senior practitioners of high standing within the health community. They provide good advice to support safeguarding of children. Designated health professionals have appropriate access to safeguarding supervision and are represented on the DSCB. It was unclear however, how safeguarding supervision was delivered to the named doctors in the provider trusts. Named nurses are all very experienced practitioners with a high level of knowledge about children, expertise in supervision and qualifications in training. Named nurses are supported to access leadership training. They have job descriptions and are regularly supervised by the designated nurse.

5.5 The Child Death Overview Panel (CDOP) is well established and works effectively across Derby City and Derbyshire. The panel has a good record of effective external challenge to its constituent trusts and provides leadership to named professionals. Issues identified in the CDOP report of 2009 have been taken forward in part or in full since then. Partners have co operated well and social care partners have committed resources for implementation. Some notable initiatives were seen, particularly the robust implementation of the ‘sleep safe’ programme including a visual check and completion of an assessment by the midwife. An audit trail shows that a high proportion of mothers changed something as a result of the assessment and since its rollout there have been no deaths attributable to unsafe sleeping. Similarly, a widespread programme is in place to alert mothers to the dangers of shaking a baby and all new mothers are required to watch a DVD and sign a contract before discharge. The draft self harm strategy is another initiative where the CDOP the work has informed practice in A&E. As a result all YP admitted as a result of self harm now have an assessment before leaving, and local hospitals always have a CAMHS consultant on call for advice.
5.6 Senior staff working in adult mental health care had good awareness of the potential impact on children who were in contact with adults who have mental health needs. There is recognition of the need for increasing partnership arrangements and awareness-raising across the county to safeguard children in families where there are adult mental health needs. A county-wide multi agency training package was being developed through the DCSB to address this issue more consistently.

5.7 Derbyshire has no in-county tier 4 services and it was reported that at the present time, tier 4 placements for young people in crisis were not always consistent and could be made in any of a wide range of services, some a considerable distance away. The PCT are looking to improve access to CAMHS tier 4 services including outreach support to ensure children and young people receive a service appropriate to them, however improved arrangements remain unclear.

5.8 Arrangements provide a generally good service for children and young people subject to alleged sexual abuse. At the Chesterfield Royal Hospital children are examined in a new, well equipped suitable environment. The forensic examination arrangements are suitably located in the paediatric outpatients building, with its own separate waiting area and a sealed suite exclusively used by children. Examinations are undertaken by a consultant paediatrician and all required equipment is available including a colposcope linked to a DVD. The suite liaises closely with the safeguarding lead nurse and formally shares information on referrals of young people aged under 18 so that the school nurse, health visitor or GP can be involved if necessary. A dedicated facility is also provided at the Royal Derby Hospital for children in the south of the county.

5.9 Urgent care settings have their own systems and arrangements in place to identify and safeguard vulnerable children and young people who attend. The accident and emergency unit within Chesterfield Royal Hospital and the community hospitals and minor injuries units (MIUs) run by DCHS have good awareness of risks to children. They have their own systems but these are unable to share information sufficiently quickly to identify children who attend repeatedly to different locations in a short time. When children attend A&E at the general hospital, the IT system automatically identifies repeat attendance within two weeks or one year and this is checked by the triage nurse and treating clinicians. In MIUs similar checks on internal records are also made to identify children and young people who have repeated attendance there. There is a system of reviewing the records of all children who attend an emergency unit within a Trust, overseen by the paediatric liaison manager and named nurses. Doctors, health visitors, social workers and school nurses are also informed of attendances and alerted to safeguarding issues including repeat attendees and those who do not attend follow up children’s out patient’s clinics. Where staff have concerns at presentation, checks are made with other agencies directly through the safeguarding nurse or Call Derbyshire to see if a child or young person is looked after or known to services; however this is not a robust system to identify particularly vulnerable children.
5.10 The serious case review process has provided important opportunities for multi-agency learning to review the effectiveness of partnerships and local service provision. The designated safeguarding doctor and nurse have both played a key role in the delivery of serious case reviews and furthering the recommendations and action plans which emerge. Reviews have been followed up in action planning although there have been some delays in completion and agreeing action county-wide. There are examples of service changes as a result of reviews, for instance the recent self-harm and suicide strategy, and the county-wide access to an on-call clinical team, for children at risk.

6 Outcome 11 Safety, availability and suitability of equipment

6.1 Arrangements for children’s emergency and unplanned care are variable county-wide and some facilities are unsuitable. In southern Derbyshire, unplanned care for children is provided in the paediatric unit at the Acute Trust in Derby. However in the Chesterfield and north east district, services are delivered in the Acute Trust’s general accident and emergency department which is poorly equipped to meet children’s needs and particularly lacking in toilet and suitable waiting facilities. The new well equipped children’s resuscitation room is a very positive feature however. Many children attend community hospitals and minor injuries units provided by DCHS. The community resources at Ripley and Ilkeston have dedicated treatment bays for children but few other facilities. Further focus is needed to adopt a standard of provision that ensures that there are appropriate, suitable, safe admission, waiting and toilet facilities for children and young teenagers across Derbyshire’s urgent care settings.

6.2 During the inspection visit to the A&E unit at Chesterfield Royal Hospital it was observed that systems were not effective in ensuring hygiene and infection control measures were up-to-date. The issues were drawn to the attention of managers at the time.

6.3 Provision is unsatisfactory in respect of meeting the needs of adolescents needing inpatient accommodation in both acute general hospitals. This presents difficulties and risks in the case of older teenagers especially those between 16 and 18 who are sometimes unsuitably admitted to adults ward but may also be unsuitable to be accommodated with young children.

7 Outcome 12 Staffing recruitment

7.1 All health providers declared their compliance with safe recruitment arrangements including CRB checks for their staff.
8 Outcome 13 Staffing numbers

8.1 Health Visitors are provided by DCHS across Derbyshire. School nurses are provided by two different organisations geographically. Variable arrangements impact on the service level which is provided and communications between professionals. Case load reassessment is starting to help to address inequities and targeting of resources on early intervention with the most vulnerable families. The universal health programme is starting to be delivered with a risk based, skill mix approach to which further work is ongoing.

8.2 Staffing levels of health and social care posts providing CAMHS services county-wide are inequitable to ensure all children have access to the help they need. The dedicated CAMHS service for looked after children is not fully staffed, with vacancies in social work posts and no specialist psychologist. As a result access to specialist CAMHS services for looked after children is also inconsistent, and in some cases not timely or not available.

9 Outcome 14 Staffing support

9.1 Safeguarding training is good. There is strongly improved access and attendance at safeguarding training and more robust systems are being put in place for monitoring compliance by role against the specified standards. Systems are not yet in place to monitor the implementation of agreed training programmes in practice. The first data set on compliance against safeguarding training objectives from data captured through the CQUIN commissioning tool is expected to be reported shortly.

9.2 Looked after children specialist nurses deliver a wide range of training to other stakeholders to improve the well being of children and raise the awareness of the needs of looked after children.

9.3 Progress was being made in increasing co-location of staff and where it is in place, this contributes to multi agency understanding and to early intervention arrangements. Health partners have shown strong commitment to developing their children’s workforce. However, there is insufficient focus on the skills mix to meet the specialist needs of children accessing emergency treatment in Chesterfield Royal Hospital and DCHS minor injuries units and community hospitals.

9.4 The skills mix in unplanned care settings provided by CRHNHSFT and DCHS is inadequate to ensure children receive appropriate treatment. CRHNHSFTs own monitoring of the extent to which under-1 year olds were examined by specialist paediatric staff identified an ongoing issue which we found replicated in the overall profile of nursing staff in their A&E and in community units run by DCHS where the staff skills mix needs to be enhanced to ensure specialist care.
9.5 Health partners have made a great deal of progress in improving arrangements for staff supervision. Named and designated nurses and doctors have access to good training to deliver supervision, and arrangements for supervision have improved in most areas. Nurses access both internal and externally provided shared training with school nurses and both receive supervision from the safeguarding nurse employed by the PCT. Health files we viewed showed an increased use of supervision templates and greater frequency of supervision though this was not yet consistent across teams.

10 Outcome 16 Audit and monitoring

10.1 Disparate IT and other systems between health providers and health professionals around the county are a major barrier to effective monitoring and preventative arrangements. Performance monitoring by health partners of safeguarding arrangements is variable with different systems in place in the north and south of the county and not all providers have electronic recording systems. For example, accident and emergency departments, community hospitals and minor injury units (MIU) across the county have their own alert systems in place to record previous visits and to track concerns but they are not compatible with those in other units. In the absence of a comprehensive electronic recording system it is not possible for one hospital or MIU to know, unless a parent tells staff, whether the child or young person has presented at a different hospital or MIU within a short period of time. Within individual hospitals or units tracking systems are more robust with a paediatric liaison manager and named nurse screening all attendances within the departments and MIUs and sharing the information with community staff. This includes repeat attendees and those who do not attend follow up children’s outpatients’ clinics. However, the lack of compatible electronic systems means there is often a delay in notifications reaching partner agencies. The relationships of school nurses to other professionals are also particularly affected by lack of direct access to electronic records systems.

10.2 Some monitoring of health outcomes for looked after children is starting to develop but is not yet adequate. The split of providers between north and south areas has been a barrier to developing common approaches and integrated reporting to improve trend identification. Some audit arrangements are in place for health assessments, reviews and plans but are focussed on quantitative factors rather than their quality or capture of outcomes. The impact of CAMHS services for looked after children is not being measured.

10.3 In the absence of a designated nurse for looked after children, responsibilities had been distributed too widely so that not enough emphasis had been paid to drawing together consistent information about the aims, services and performance of the looked after children teams. Regular arrangements for producing an annual report covering the looked after children teams work were not in place making it difficult to assess their contributions and challenges. Each specialist nursing team had previously reported separately and at differing intervals and different formats so it was impossible to monitor progress.

10.4 There are arrangements within service areas to track and report on specific processes that contribute to safeguarding, for instance named nurses consistently record their advice to stakeholders.
11 Outcome 21 Records

11.1 The quality of health records examined is variable, and in some cases inadequate. A variety of recording systems is used as a result of differences in providers. There is good evidence in files of tracking young people who do not attend for health assessments and appointments or attended urgent care settings. Most files examined lacked a chronology of health events or these were not up to date. In a few cases multiple records were disjointed and lacked continuity. Records did not reliably include clear planning about key issues, or an assessment of the outcomes. All records contained health care plans though their quality varied and they often give insufficient focus to meaningful outcomes for children. Consent to treatment forms were mostly present.

11.2 There were some good examples of innovative work to improve consistency of record keeping. Some very good templates had been introduced to assure consistency of responses, for instance across midwives in the CRHNHSFT.

12 Recommendations

**Immediately**

- Chesterfield Royal Hospital NHS Foundation Trust to ensure that all mattresses and toilet facilities in Accident and Emergency areas meet required infection control standards and that regular infection control audits are undertaken and appropriate actions implemented to safeguard children and families using the service.

**Within three months:**

- *NHS Derbyshire County, health partners and the wider partnership to agree to establish a CAMHS service that delivers equity of service specification, access, pathways and arrangements and is accessible to all children and young people irrespective of where they live in the county. To review the lack of provision of a tier 4 service which currently can result in a young person in crisis being admitted to an adult ward.* *(Ofsted)*

- *NHS Derbyshire County should ensure care leavers are provided with a full summary of their healthcare history in a format suitable to their needs.* *(Ofsted)*

- NHS Derbyshire and health partners to clarify and strengthen arrangements to ensure timeliness and the ongoing full engagement of all partners in SCR and IMR processes to include delivery of agreed action planning.

- NHS Derbyshire and health partners to agree arrangements for producing a regular timely annual report on service performance of the looked after children teams, evaluating their contribution to outcomes and clarifying work plans which address priorities and challenges in delivery of services.
Within six months:

- **NHS Derbyshire and health partners to ensure looked after children, young people and care leavers have fast tracked access to a CAMHS service that is able to be accessed equitably whether the child or young person lives in the north or the south of the county. (Ofsted)**

- **NHS Derbyshire to develop a consistent countywide approach to the commissioning of initial and review health assessments for looked after children and young people, ensure that they are carried out by appropriately trained individuals and monitored to ensure consistent good quality of assessments countywide. (Ofsted)**

- **Derbyshire County Council, NHS Derbyshire County, Chesterfield Royal Hospital NHS Foundation Trust and NHS providers of accident, emergency and urgent care services to ensure a rigorous system is in place that safely stores and provides up-to-date information regarding children and young people with a child protection plan and allows for secure and timely transfer of information between health providers. (Ofsted)**

- **NHS Derbyshire County to address consistency and caseload management in respect of designated and named doctor roles for safeguarding.**

- **NHS Derbyshire County to address inconsistent arrangements for compliance with guidance in respect of designated and named health practitioners for looked after children.**

- **NHS Derbyshire County to review commissioning of in patient provision to ensure the needs of adolescents can be safely met in both acute general hospitals, particularly older teenagers aged between 16 and 18 who are sometimes unsuitable admitted to a adults ward but are unsuitably accommodated with young children.**

- **NHS Derbyshire County to review the commissioning and provision of urgent care for children and address the skills mix of nursing staff to ensure children have access to specialist care.**

- **NHS Derbyshire County to review commissioning and provision of urgent care for children to agree a standard for the environmental facilities for children and to develop a plan to improve existing facilities to this standard.**

- **NHS Derbyshire County should review commissioning and provision of health visiting services and case loads to ensure the most vulnerable families county-wide have equity of access to targeted services.**

- **NHS Derbyshire and health partners should ensure a county-wide approach to improve and sustain the quality of recording within community healthcare records to include chronologies, risk and contingency factors and to ensure it complies with guidance.**
- NHS Derbyshire and partners should review arrangements for improving the quality and consistency of information given to parents, including at birth and at key transitional times and in relation to contingency arrangements to support children and their families.

**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](mailto:childrens-services-inspection@cqc.org.uk) and it will be followed up through the regional team.