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 inspection 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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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 and Mental Health Operations, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within 20 working days of receipt of the final report.*
The Inspection Process

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

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

Context:

Commissioning and planning of child health, young persons’ services and primary care are undertaken by NHS Derby City with universal services such as health visiting, school nursing, and paediatric therapies delivered primarily by Derbyshire Healthcare Foundation NHS Trust. Universal health safeguarding services are hosted by Derbyshire Healthcare Foundation NHS Trust.

The acute hospital providing children accident and emergency services is Royal Derby Hospitals Foundation NHS Trust, with minor illness & injuries provided by Derby Walk in Centre 8am to 7pm 7 days per week. Maternity and newborn services and community maternal health are provided by Royal Derby Hospitals Foundation NHS Trust. Children and families access primary care through one of thirty one general practices (GP) and 1 walk in centre as detailed above. Derby Open Access Centre provide GP drop in services 8am to 8pm, 7 days per week and Derbyshire Health United provide GP out of hour’s services, (unscheduled care settings).

Child and adolescent mental health services (CAMHS) are provided by Derbyshire Healthcare Foundation NHS Trust through a commissioned service under a standard NHS contract. There is no tier 4 provision within Derby; access to beds is commissioned from Nottingham Healthcare NHS Trust.
Children with complex needs services are provided by Royal Derby Hospitals Foundation Trust KITE team and through the Light House under a Section 75 arrangement with pooled budget. Services are also commissioned from the voluntary sector to support children with complex needs and palliative care needs.

Joint commissioned services with Derby City Council include CAMH services, monitored by the CAMHS Partnership; tier 2 primary mental health worker services, specialist services for 16 /17 year olds, a complex behaviour service for children with learning disabilities and mental health problems, targeted mental health in schools (TAMHs), and services for children who have been sexually abused. Other joint arrangements with Derby City Council are primarily joint funded e.g. the Integrated Disabled Childrens Service and commissioning placements for children with complex needs.

Looked after children services (LAC) health services are provided by Derbyshire Healthcare Foundation NHS Trust to deliver statutory health requirements for LAC and to work with Derby City Council to provide consultation and support for staff as well as direct work with children and young people in residential and foster care.

General – leadership and management

1. The contribution of health agencies to keeping children and young people safe is adequate; being healthy is adequate with effective leadership and management within and across health services. Good attendance by all health providers at the local safeguarding children board (LSCB) and the recently reconfigured Childrens Partnership Board. However, leadership at the LSCB has been inconsistent with four directors of children services within the last year and the recent appointment of an independent chair. As a consequence, there has been an inconsistent level of challenge, strategic direction and holding health representatives to account although more recently this has started to improve. No reports from the looked after children (LAC) health team have been requested or submitted to the LSCB. There is no corporate parenting board, consequently health organisations report a lack of strategic rigor and direction for looked after children.

2. Health organisations have robust safeguarding governance frameworks with concurrent and fully implemented safeguarding policies and procedures. However, the monitoring of implementation within practice is inconsistent. There is good executive level accountability and reporting structures for designated and named safeguarding professionals. There is good engagement with the countywide child death overview panel (CDOP) and effective sharing of information. There is increasingly good involvement of general practitioners within safeguarding and children protection arrangements.

3. Well developed joint commissioning arrangements are in place for a wide range of services, and further developments are planned.
Outcome 1 Involving Users

4. There is good access and well used interpretation and translation services enabling full health assessments of children and young people to take place. Some staff have learnt sign language, which has improved communication with children during consultations. Some maternity staff have also learnt to speak Romany, which has improved their acceptance and engagement of Roma families with maternity services, and have worked with community leaders to become accepted by the various community groups.

5. Through good and proactive engagement between looked after children and health staff and in response to an identified high pregnancy rate within the looked after population, young people have developed a wide range of ‘young people friendly’ sexual health information and services.

6. Care leavers, irrespective of what age they leave care, are not given a copy of their health history. Care leavers are signposted to the multi agency staffed ‘Aspire centre’. Looked after children (LAC) health staff previously offered ‘drop in’ sessions for care leavers at this centre; however, these were not well accessed and ceased, although the reason for the lack of use was not ascertained. Care leavers who met with inspectors confirmed that they were registered with general practitioner services and dentists and knew where they could contact the looked after health team if they had any concerns.

7. Adult mental health staff are completing training to enhance their awareness of autistic spectrum and attention deficit hyperactivity disorders as it was recognised that this was a deficit in their knowledge and skills. This is an area of concern for parents of children with these conditions seen during the inspection who had raised the issues with health staff especially those relating to the poor quality of provision and lack of empathy for, and understanding of, young peoples’ needs specifically within adult health and social care services.

8. A good range of new sexual health promotion materials for all young people, (and materials on associated risk taking behaviours) have been produced as part of the revised teenage pregnancy strategy. However, these have only been recently implemented therefore no evaluation has taken place. Contraceptive services have been developed after consultation with young people and are now provided in locations identified by them. This includes the dedicated young person clinic within the genitourinary medicine service (GUM). The college based C-Card (condom distribution scheme) is well accessed by young women and young men, the latter of which are not all students at the college. There is a good ‘take-up’ of the scheme from the local Asian community, attributed to the anonymity the service.

9. Following consultation with looked after children, the LAC health team provide a good range of leaflets and health promotion related information, in age appropriate formats, however their effectiveness has not been evaluated.

10. There are a good range of young people focused substance misuse prevention activities, with young people developing health promotion materials that have been successfully used within the schools and local colleges.
11. There is inadequate involvement of parents, children or young people involved in, or subject to, child protection procedures when developing and reviewing health services.

Outcome 2 Consent

12. Consent to undertake looked after children health assessments and reviews are gained in accordance with national recommendations, and recorded in the health files.

13. Unscheduled care settings ensure that age appropriate, consent competency assessments are completed to ascertain if the young person is able to give their own consent. If the competency test is not reached, effective procedures are in place to ensure that the parents/carers consent is obtained prior to any treatment being offered. There is good recording of consenting responsibilities in the Royal Derby Hospitals NHS Foundation Trust children’s accident and emergency department (A&E) information system, ensuring safe and appropriate consent.

Outcome 4 Care and welfare of people who use services

14. All initial health assessments are completed by a medical practitioner. However, there are some delays in arranging initial health assessments by children’s social care, resulting in a challenge for health staff to ensure health assessments are completed within 28 days of coming in to care. Local data for 2009/2010, shows that this is currently being achieved.

15. Strength and difficulties questionnaires (SDQs) are completed by children’s social care. However, these are currently not shared with health staff and are not used as part of the health reviews. An electronic solution has been agreed to share information; however lack of capacity within social care has delayed the implementation. There is good engagement between the health looked after children team and the independent review officers (IROs), who meet on a regular basis to monitor and quality control health action plans.

16. There is good completion of health reviews, with a 96% compliance rate, for all for children and young people with complex health needs and for those who reside in the local residential homes. The 4% non-compliance is due to the young person refusing a health review, despite the looked after children nurse offering a choice of venues and appointment times.
17. The named LAC nurses are allocated to each of the residential children’s homes, providing good access to sexual health and personal relationship education for both the children and young people who are often not in mainstream education, and also for the staff in the residential home. The dedicated LAC nurses are able to administer emergency contraception to looked after young women, improving the access to this service and enabling the early identification and monitoring of any vulnerabilities and other risk taking behaviours. School nurses provide good access to health promotion services for looked after children in mainstream schools and in the pupil referral unit, and enable these young people attend the ‘drop-in’ sessions, as part of the universal provision for schools.

18. There is effective communication with other authorities for looked after children placed out of area, and for those from other authorities placed within Derby City. Risk assessments are good and ensure that the most appropriate person undertakes the health review, with good identification of health needs. However, the ongoing monitoring of health needs is less well developed, with poor use of audits and quality control processes. This has been recognised and a new system is currently being introduced.

19. There is good process of notification of a ‘change in circumstance’, regarding a looked after child or young person from children’s social care services to the LAC health team that enables effective tracking and monitoring of the child or young persons’ to ensure that health needs are met. A secure electronic transfer system has been developed to assist this exchange of information and to enable health assessments to be booked in a timely fashion but this is not yet fully implemented.

20. There is a good referral and review process to child and adolescent mental health services, (CAMHS) developed as a result of a serious case review, using the choice appointment system. Emergency appointments are seen immediately within the same day and most referrals are seen within 4 weeks. Appropriate signposting to alternative services for those referrals considered inappropriate is embedded. There are effective pathways for staff to refer to both mental health and emotional health and wellbeing services, with thresholds well understood. There are effective multi agency monthly meetings involving CAMHS, primary mental health workers, clinical psychology services, acute services and the dedicated LAC CAMHS team where all referrals are reviewed, resulting in a significant reduction in the number of duplicate referrals and streamlining both the referral and communication processes. The multi-agency consultancy model is providing appropriate support and advice to professionals, with good multi-agency training and intervention, working at tier 2 with key agencies involved to protect vulnerable young people. Agencies include social care, residential home staff, housing and the voluntary sector. Good cross boundary working and ‘team around the child’ processes are embedding, with good individual case based discussions enabling further exploration of concerns and appropriate onward CAMHS referral. This approach has been recognised as national good practice.
21. There are no tier 4 CAMHS beds in Derby City or Derbyshire; block contracts are in place with neighbouring authorities. However, there is a lack of capacity resulting in delayed access to these beds for young people. In some instances the young person has to travel some distance away from their families restricting contact with their families and this, as well as the out of area provision, results in the young people being brought back to Derby City too early and placed in tier 3 services. The contract does not meet the more complex need so placements for young people are commissioned as required. East Midlands Specialised Commissioning Group have taken over the responsibility for commissioning this service from only April 2011.

22. There are a good range of accessible and well used sexual health and contraception clinics and ‘drop-in’ services across the Derby City. However, the impact of these in reducing the teenage conception rate has not been realised. Whilst the teenage conception rate target shows an overall reduction of 19% compared to 13% nationally. Teenage conception and pregnancy rates remain high (51/1000 England average 39.2/1000) with a low termination rate, despite revision to the teenage pregnancy strategy and a visit from the National Support team. Culturally sensitive work and work with the young person parents’ has only recently commenced, to change cultural assumptions and raise aspirations, the impact of which is too early to evaluate. There have been a number of targeted projects within high pregnancy rate areas but the overall impact of these has not reduced the conception rate. Young people, however, have positively evaluated the provision and report high levels of self esteem and career aspirations after engagement with the projects. There is good dedicated enhanced sexual health education alongside personal relationship education within Kingsmead School and the pupil referral service. The service has been running for 3 years and has been positively evaluated by the young people.

Outcome 6 Co-operating with others

23. A good level of support is provided to the residential children home’s staff by the primary mental health workers (PMHW) (tier2) enabling fast tracking of cases to tier 3 CAMHS. The ‘team around the child’ professionals meeting arranged by the dedicated CAMHS worker for looked after children, is ensuring the implementation of treatment action plans but evaluation is less well developed. These approaches are effectively working to support the emotional health and well being of looked after children and support their carers. Some parents of children with learning disabilities reported delays in CAMHS appointments, recently due to staff turnover, although data shows appointments are seen within 12 weeks. Good foster carer support is provided by CAMHS workers and clinical psychology services through one-to-one support tailored to their individual needs to prevent placement breakdown. The dedicated looked after children health team provide a good range of training to support foster carers and maintain placement stability.
24. CAMHS staff are not regularly invited to LAC and children with learning disability and disabilities care leaver pathway planning meetings (coordinated by social care), despite still being actively involved with the young person. Consequently, not all information is available for decision making and transition planning. There is a flexible upper age range for treatment provision which is enabling better individual tailored transition planning and joint working with adult health and adult mental health services.

25. There are good close working relationships and improved staff supervision of mental health cases from the dedicated mental health worker within the youth offending service. Evaluation of the improved working relationships and having a dedicated worker is starting to show improvements in the health outcomes for young people and has improved the transition pathways.

26. The 'Think family' approach is not well established within adult services, however, frontline practitioners report that this is starting to improve and named children safeguarding practitioners and CAMHS staff are now receiving requests from adult mental health services. The 'Think family' and young carers' ethos are becoming more embedded within acute adult healthcare and adult accident and emergency services, with an increased recognition of the needs of young carers. The common assessment framework (CAF) and care programme approach (CPA) used in adult mental health services are currently being aligned as an enabler for frontline practitioners.

27. Effective use of the East Midlands safeguarding forum for nurses and midwives is improving communication and processes across the region. The forum monitors chaotic families and ensures good sharing of unborn babies' birth plans, to protect them from harm.

28. Feedback from referrals to children’s social care is received, in most cases, however, this is only verbal and no written feedback is received, resulting in incomplete health safeguarding records. Children's A&E staff often receive no direct feedback on referrals from social care; however, the highly valued health visitor liaison and named nurse follow up all referrals, and ensure that staff receive feedback. These post holders provide effective quality control of all referrals and cause of concern forms, and ensure that all cases have been appropriately referred. All health escalation policies are effective. Out of hours contact with children’s social care is mostly good. Thresholds are understood with recent clarification on the use of the CAF, which is not used as a referral tool.

29. There are adequate transition points between adolescent services, adult services and the younger adult health services, especially in the areas of Attention Deficit Hyperactivity Disorder (ADHD), self harm, youth offending services and sexual exploitation services, which are starting to improve the transition experience for the young person and their family.
30. There is adequate and variable access to respite care provision, with families reporting no respite for under 8 year olds who have learning disabilities and difficulties. Parents of older children rated the respite provision from the Light House as being of a very good quality with good support for parents and carers, complimented by the support they receive from staff from Umbrella. However, parents and carers report an inconstant approach by services, which results in some confusion and families not receive the services they are entitled to. There is good access to a highly valued dental health service for children with learning disabilities and difficulties and for children with dental anxiety.

31. There has been good and full engagement of health organisations and the designated and named health staff, with a number of national high profile serious case reviews, including Operation Retriever, with some activities being effectively led by health staff. There has been good health engagement with the subsequent changes within child protection and sexual exploitation processes. The impact of the actions is still on going at the time of the inspection.

32. An adequate range of termination of pregnancy services are provided, which includes Royal Derby Hospitals NHS Foundation Trust, pathways for referrals are well established with young women being well supported throughout the termination pathway. However, for those who wish to have a termination of pregnancy when the gestation is over 14 weeks, they have to access services out of Derby City, with poor transport networks; young women are not always keeping appointments. There is currently no monitoring of the follow up of young people who have accessed or not been able to access termination services, or the follow up provision provided by the dedicated sexual health staff.

33. There are good and effective referral pathways and engagement with the family nurse partnership, which has worked with 100 families and is currently working with 80 families, including fathers and fathers-to-be. Research findings to date show that there is an increase in the young person’s self esteem resulting in them returning to education and employment, with a low rate of unplanned second pregnancies.

34. There is an effective range of outreach sexual health and substance misuse services working through and with the youth offending services to reduce risk taking behaviours. Good effective partnership working within all substance misuse services and the implementation of the ‘think family’ approach is starting to become embedded. Service evaluation is effective with good engagement with young people, with no re-offending for those involved with the service and young people remaining ‘clean’ and able realise their aspirations.

35. ‘Breaking the Cycle’ has well embedded working arrangements and referral processes with adult services, which are effectively addressing issues of the hidden harm for children of adult substance misusers. Locality based working and a single point of access has improved access to services, including those services provided to looked after young people in residential care settings. Good partnerships working with schools and the pupil referral unit, has resulted in an increase in referrals (up 100%), with either individual treatment or group sessions that are showing improved outcomes for children and young people.
Outcome 7 Safeguarding

36. There is good electronic information sharing of attendance details between the walk in centres and the dedicated LAC health team. The system has a comprehensive range of alerts for all children and young people who access services, including frequent attendees and this information is effectively shared with community and primary care services. The children’s A&E information system ‘flags’ include: known to social care, allergies, parents are known to have enduring conditions, number of attendances etc. Effective use is made of the free text box to add further comments relating to the alert and to review old alert notices. The free text allows for additional health and social information or instructions to be recorded, which is then sent to general practitioners or children’s social care for further action.

37. Effective communication process from Royal Derby Hospitals NHS Foundation NHS Trust children’s A&E and community and primary care services are in place. Community practitioners and GPs confirmed that they receive timely notifications and as required, follow up the child/family ensuring that the child/young person remains safe. However, the practice based meetings do not always have the named health visitor liaison for the general practice in attendance, resulting in less effective information sharing.

38. There is good adherence to the recently reviewed self harm pathways following a serious case review, with the adult self harm pathway now including assessment of the adults with caring responsibilities for children. This has yet to be evaluated. However, the lack of tier 4 CAMHS beds remains a challenge to full implementation of the pathway. All accident and emergency staff have good access to mental health support; however, within adult accident and emergency services and the younger adult service, support is variable especially out of hours. The potential for harm and the development of strategies and/or safeguarding cause for concern referrals are made appropriately to social care( both adult and childrens) ensuring that the young person remains safe.

39. As a result of CDOP campaigns such as safe sleeping, there has been a reduction in sleep related deaths. Suicide prevention and fire safety campaigns are yet to be evaluated fully for their impact. A rapid response team is in place but, it is only staffed by a doctor with access, as required, to the health visitor for sudden infant death who will provide support to families. This is meeting the local needs.

40. Some GPs report receiving a lot of information relating to CDOP and especially serious case reviews due to the recent high profile cases, whilst others report receiving no information from CDOP. GPs are not auditing the implementation of the recommendations or the effectiveness of safeguarding arrangements within their practices.

41. GP safeguarding practices leads are introducing a ‘did not attend’ (DNA) review process to ensure that all cases are assessed and appropriate measures are in place, however, it is too early to measure impact.
42. Maternity systems now ‘flag’ safeguarding concerns and copies of minutes of any child protection conferences and the birth plans, are stored on the system, enabling better information sharing. The substance misuse midwife effectively uses the pre-caf to assess parenting and support parenting capacity. There is effective information sharing and partnership working with cases of domestic violence, with good engagement with the multi agency risk assessment conference (MARAC) arrangements.

43. School nurses deliver, or support education staff to deliver, sexual relationship and personal health and relationship education, with some school nurses successfully completing the continuing professional development module. However, there is variable level of support from all the secondary schools and as a result school nurses are now holding well attended ‘drop-in’ sessions at youth clubs after school hours. Emergency contraceptive and c-card services are available at these clinics as part of the teenage pregnancy strategy; however, the effectiveness in reducing conceptions has not been evaluated.

44. There are different and changing cultures and communities within Derby City and through effective use of public health data, an assertive outreach project has started to have an impact with increasing use and engagement with services from the local communities. Community practitioners and midwives are currently receiving training to understand and appreciate the different cultural expectations from health services. Effective use of open mornings within children centres and GP surgeries, with interpreters being present, is starting to increase the access to treatments and is improving the quality of health assessments. There is a good range of health provision for Roma families.

45. Good and regular professional meetings are held between health, social care, children centres, and education staff, where CAFs are effectively reviewed and discussed. Information sharing at these meetings has improved the early identification of children transferring on/off a child protection plan from a CAF (includes the targeted mental health in schools -TaMHS project - for sexual exploitation cases).

46. There is good identification at the monthly substance misuse meetings, ensuring that safeguarding issues are identified and appropriate action is taken. There is no formal analysis of the effectiveness of these meetings. However, a number of individual cases show children have been protected from harm as result of these meetings. An effective and well accessed CAMHS ‘drop in’ service based within a youth centre, is providing good immediate support and assessment to vulnerable individuals, which has led to referrals and ongoing direct tier 3 CAMHS work and/or safeguarding referrals to children social care.
47. Good use of GP practice based information systems which ‘flags’ at risk families, children and young people, including; flags’ for LAC, families known to social care, those on a child protection plan, missing children and frequent attendees. However, there is an inconsistent use of flags and coding across all practices. GPs have effective information sharing practice meetings where families of concern are discussed. However, the health visitor engagement at these meetings is variable; the link health visitor role is only a contact name from the GP’s perspective.

48. Adult A&E services effectively identify children that may be at risk of harm due to parental/adult concerns and these are referred to social care as well as notified to the health visitor liaison in children’s A&E and the named nurse for safeguarding. The health visitor liaison post ensures that the child’s health notes have an alert placed on them should they attend children’s A&E. Effective and good information sharing with ambulance services and A&E staff regarding the home situation or the circumstances, in which the child was found, ensures that referrals to social care are made appropriately.

49. There is good attendance by GPs at child protection case conferences, and health staff at strategy meetings, although for GPs this remains a challenge due to the time of the meetings. Case conference reports are effectively shared within practices.

50. Good use is made of the ‘SPACE’ facility for young people to access a range of sexual health services. The service has been relocated in response to consultations with young people. The sexual assault referral centre is based within Derbyshire County and is occasionally used for 16 and 17 year olds. Specifically trained community paediatricians, within children’s A&E are trained to support and undertake some of the assessments following a sexual assault depending on whether a prosecution is pending.

51. The LAC named nurses provide accessible sexual health services, including contraceptive services and support to access genito-urinary medicine services, to the residential children homes. Education to both the staff and young people based in the residential children homes, although highly valued by the young people; there has been no formal evaluation of the effectiveness of the service, in reducing conception rates.

52. The youth offending service health clinic provides timely access to basic sexual health services, with positive users engagement, resulting in an increased number of people who misuse substances attending the clinics, (previously this cohort did not access services). The health clinic has effectively identified vulnerable young people, with a range of successful interventions to protect the young person from harm and risk minimisation.
53. There is no robust monitoring of teenage pregnancy reduction strategies for both concealed and second conceptions pregnancies. The dedicated midwife for the Roma families has effectively used interpretation services for families from European communities, to produce increased take up of contraception and sustained engagement with sexual health services, within these communities. Culturally sensitive services are still to be fully embedded across all communities. There remains a gap in provision and support for the parents of teenagers to ensure that they are supporting the ‘delay’ messages and supporting the raising of aspirations to reduce the number of conceptions.

54. There is good engagement with the multi agency referral and assessment conferences (MARAC) by health staff including health visitors and midwives, for cases of domestic violence and associated domestic violence linked to substance misuse. There are effective discharge planning and transition to adult service arrangements in place which ensure that treatment regime continues and the young person remains engaged with services. Addaction works within the antenatal clinics and with the victims of domestic violence to ensure the unborn baby is protected and risks are minimised.

55. An effective and well accessed CAMHS ‘drop in’ service based within a youth centre is providing good immediate support and assessment to vulnerable individuals, including those who may have a tendency to misuse substances, or self harm, which has led to ongoing direct tier 3 CAMHS work and/or safeguarding referrals to children social care.

56. A good dedicated service is provided by the CAMHS complex behaviour team working with children with disabilities. There are still concerns amongst commissioners that the service and the psychological services are not within the same organisation. This has been the same for 5 years and no progress has been made to address this. However, the good professional partnerships, including support and supervision provided by the services to professionals working with children with disabilities, is enabling early intervention and quicker resolution of issues.

Outcome 11 Safety, availability and suitability of equipment

57. There is a new purpose-built unit dedicated children’s accident and emergency department at Royal Derby Hospitals NHS Foundation NHS Trust. There is a good range of age specific equipment, include resuscitation, monitoring and play equipment. The treatment rooms dedicated waiting areas have been designed specifically to allow staff to have very good sight of children and their parents/carers, the only exception being the dedicated outside play area. There is an age appropriate, 3 bedded baby/child/young person resuscitation facility which is separate from the adult area, built within the children’s A&E.

Outcome 12 Staffing recruitment

58. Health organisations report in the section 11 audits that all staff are criminal records bureau checked.
Outcome 13 Staffing numbers

59. Workforce development frameworks and strategies are in place and subject to regular review to ensure that they meet both the service specification and population needs.

60. An increased investment from the local authority and health into the LAC nursing team occurred during 2009/2010, however, recruitment was slow and high sickness levels resulted in the team not becoming fully established until November 2010. The looked after children nurses are now up to establishment and linked to the three localities which is improving partnership working with children and family services. Further, there has been an increase in the supervision to the LAC team as a result of dedicated time from safeguarding team which is supporting the LAC team to undertake their roles fully.

61. Vacancy rates remain a challenge within health visiting and school nursing services; however, results of the skill mix review and service redesign are too recent to have had an impact on services for young people. Health visitors and school nurses report that the recent serious case review actions have stretched their capacity and required prioritisation of case loads. The capacity for the named safeguarding health professionals within Royal Derby Hospitals Foundation NHS Trust remains a challenge with two posts identified and yet to be funded.

Outcome 14 Staffing support

62. There is good access to supervision and medical staff support, the latter especially for school nurses and health visitors when staff are completing the health assessments or reviews. General practitioners, school nurses and health visitors receive regular training and updates to undertake the looked after children health assessments and reviews.

63. Safeguarding training compliance is variable. Safeguarding children training within Derbyshire Healthcare NHS Foundation Trust for both level 1 and 3 is at 100%, effectively monitored every quarter and reports submitted to the LSCB. The LSCB training subgroups between Derbyshire County and Derby City are being merged and approaches standardised. Training within maternity services for both level 2 and 3 is only interdisciplinary, with only 50% of midwives trained. Within Royal Derby Hospitals NHS Trust 84% of staff in key priority area have attended the interdisciplinary level 2/3 training; however, trust wide the rate is at 34%. The training was only introduced in August 2010, and this coupled with lack of named nurse capacity has had an effect on compliance rates. General practitioner training compliance is 85%, however, there remains discrepancies as to which levels of training this applies to as some GPs are unclear as to what group of training they should be attending and think they have not completed the correct sessions. All other staff interviewed during the inspection confirmed that they were in date with their training. There has been good access to domestic violence training on a multi agency basis, however no evaluation of impact on practice. Subjective outcomes of training include an increase in appropriate referrals, and use of the CAF. However, there is a lack of robust, consistent evaluation of the impact of training across all organisations.
64. There is a good level of supervision for the named and designated health professionals with effective peer, cross regional networks and individual supervision for all staff. There is good and well accessed supervision and support for all frontline staff, with some effective monitoring of the impact of supervision. Monitoring shows effective use of supervision to protect children from harm.

65. Health designated and named safeguarding staff are fully engaged in and participate with serious case reviews. Monitoring the implementation of actions from serious case reviews and individual management reviews is ensuring lessons learnt are fully implemented, although evaluation of the recent high profile cases is yet to be completed. The designated nurse is highly valued, and has recently received a commendation from the Chief Constable regarding the contribution to a number of serious case reviews and Operation Retriever. The designated and named safeguarding health staff undertake annual audits of the effectiveness of their roles as defined by the recipients. Results show that staff highly valued the roles.

66. There are good rates of compliance, monitored by the senior matrons and staff, for the advance paediatric life support and trauma training for paediatrics by both the children’s and adult A&E staff, ensuring that there are staff on duty at all times that hold these qualifications. There are within the children A&E qualified childrens nurses on duty at all times.

Outcome 16 Audit and monitoring

67. Inaccurate LAC data recording has resulted in different outcomes and challenges in effective monitoring of compliance between health and social care staff. A solution has been identified to improve data collection within social care and share this with health, however, this has not been implemented. Health assessments rates are 74.6%, health reviews at 78% (health data for 2011, social care data 80% for the same time period), dental assessments 67.2%, both of which are worse than England averages, however, immunisation and vaccine rates are 82%, which is better than England averages (2009/2010).

68. Pathways are in place which are streamlining processes and improving health and social care data management aimed at enabling effective monitoring of health outcomes. Social care and health care have developed a secure electronic transfer of notifications of new looked after children or young people and a change in circumstances notification. However, this has been slow to be implemented due to the recent changes within capacity in children social care.

69. Information sharing protocols are yet to be fully embedded; health organisations are reviewing the effectiveness of these across the partnership and with the Derbyshire county health services. There is an improving critical analysis of performance data and serious case review activity, with more recent good management and leadership of the processes.
70. Outcomes from the safeguarding audits show that the thresholds for referral to children’s social care are better understood. Areas for further development were identified and introduced within training programmes. There was no evidence however, to show how the results were being used to improve services, or of the revised training.

71. Within general practice since the named GP role has been filled permanently (recently come into post previous role was covered by the named doctor form the primary healthcare trust), there has been an increased focus on safeguarding and ‘think family’ approaches which has resulted in an increase in referrals. The Royal College of General Practitioner toolkit is still being implemented and therefore it is too early to measure impact. Section 11 audits are monitored by health organisations, although not by the LSCB, along with the ‘markers of good practice’ which have been positively evaluated by the strategic health authority.

Outcome 20 Notification of other incidents

72. All staff are aware of whistle blowing procedures; however, none of those staff seen during the inspection had needed to use the procedures.

Outcome 21 Records

73. All looked after children files seen during the inspection were of a good quality. However, there was no evidence of supervision in the records, or changes to care as a result of supervision. There is variable quality and lack of consistency of health action plans and reviews. Steps have been taken to improve this by additional training for school nurses and health visitors, early results show improvement in quality assessments. The Royal Derby Hospitals Foundation NHS Trust obstetric records did not always correctly identify the discharge location of looked after young people and their baby.

Recommendations

Immediately

Ensure that all foster carers receive appropriate health care information when children are newly placed in their care.  (from joint report)

Within 3 months

NHS Derby City and Derby City Council must ensure that all care leavers, irrespective of when they leave care, are given a copy of their health history to ensure that they are able to make fully informed health life choices. (From joint report)

Ensure the development of local CAMHS Tier 4 beds for Derby City children and young people assessed as being in need of this service and ensure that such services are provided in an equitable and timely manner. (From joint report)
NHS Derby City must ensure that general practices involve community practitioners at their practice based safeguarding meetings, and these and the safeguarding processes within practices are systematically evaluated.

NHS Derby City must ensure that all health staff are in date with their safeguarding training to the level expected for the group, with effective monitoring arrangements to measure the impact of safeguarding training within practice.

Royal Derby Hospitals Foundation NHS Trust must ensure that the capacity within the safeguarding team is sufficient to meet the assessed need and that vacant posts are successfully recruited to.

NHS Derby City must ensure that 'think family ' is fully embedded and evaluated across all adult health services.

Next steps

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