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

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<th>Date of Inspection</th>
<th>3rd October 2011 – 14th October 2011</th>
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<td>Date of final Report</td>
<td>18th November 2011</td>
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<td>Commissioning PCT</td>
<td>NHS Kent and Medway</td>
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<td>CQC Inspector name</td>
<td>Tina Welford</td>
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<td>Provider Services Included:</td>
<td>Medway Foundation NHS Trust (MFT)</td>
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<td>Kent and Medway NHS and Social Care Partnership Trust (KMPT)</td>
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<td>Medway Community Health Services (MCHS)</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 the health providers and commissioners as well as the local Director of Children’s Services at the end of fieldwork. 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](#).
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 respective organisations 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 the CQC Regional Director, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s service 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.
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 NHS organisations listed above, but includes some areas which may apply to one or more NHS bodies where pertinent.

**Context:**

Commissioning and planning of child and young peoples’ health services and primary care are undertaken by NHS Kent and Medway with universal services such as health visiting, school nursing and paediatric therapies delivered primarily by Medway Community Healthcare and Medway NHS Foundation Trust. The acute hospital providing accident and emergency services (A&E) for children is Medway Maritime Hospital, run by Medway NHS Foundation Trust which also provides maternity and newborn services, paediatrics and community paediatrics. Children and families access primary care services through one of 62 general practitioner (GP) practices or the walk in centres including the Sunlight Centre, where salaried GPs are employed by Medway Community Healthcare, and the Urgent Treatment Centre at Medway Maritime Hospital. Out of hours services are provided by Medway On Call Care (MedOCC) at Chatham Dockside. Medway residents may also access minor injury units in Sittingbourne and on the Isle of Sheppey.

Child and adolescent mental health services (CAMHS) are provided by Kent and Medway NHS and Social Care Partnership Trust (Tier 3) and South London and Maudsley NHS Foundation Trust (Tier 4).

Services for children with learning disabilities and difficulties and who have complex health needs services are provided by Medway Community Healthcare and Medway Foundation NHS Trust.

Joint commissioned services with Medway Council include: speech and language, Young Carers support, Child and Adolescent Support Team (CAST) who work with children, young people where early emotional well being difficulties are becoming apparent. The lead commissioner for child health commissioning is provided through NHS Kent and Medway, with the responsible Assistant Director jointly funded by NHS Kent and Medway and Medway Council.

Health provision at the local youth offending institution (YOI) is currently provided through the prison service. However, looked after children (LAC) health assessments are provided by the health LAC team. LAC health services are provided by Medway Foundation NHS Trust.

Safeguarding children and adults service is provided to the PCT by Medway Community Healthcare under a service level agreement.
The health of people in Medway is generally worse than the England average; Medway has significant health inequalities. There are 66,020 children who are living, learning and growing up in Medway with approximately 12,170 children living in poverty. About one fifth of year six children are classified as obese, and though improving, fewer children engage in sport. One in five pregnant women smoke, higher than the national average and fewer than the national average lead a healthy lifestyle. Domestic abuse incidents in Medway account for 18% of all domestic incidents across all of Kent and Medway, with hotspots in Rochester, Gillingham, Chatham and Frindsbury. Teenage pregnancy levels remain high however; the latest figures indicate that the conception rate in Medway has just started to reduce. “

General – leadership and management

1. Ambitions for the development of children and young people health and substance misuse services in Medway are well articulated. There is good engagement of health organisations with other partners in active joint children and young people service planning, through an increasing number of joint appointments and joint commissioning activities. There are a number of successful pilot projects, such as the Department of Health and Department of Justice funded pilot to divert young people who are substance misusers from the court system, working with health, probation and youth offending services and the young person’s family.

2. There has been effective decommissioning of adult substance misuse services for non adherence to the contracted safeguarding requirements, which was leaving child and young people vulnerable.

3. There is good engagement by health staff at the Children Trust Board, local safeguarding children board (LSCB), and relevant sub groups, as well as the Corporate Parenting Board and the recently formed health community safeguarding committee. The level of challenge from the previous LSCB chair was robust and is continuing with the recently appointed new chair however, the level of challenge and joint working arrangements with the local police force supporting safeguarding arrangements and actions from serious case reviews is less well developed. There have only been two serious case reviews at the time of the inspection, with the health contribution graded as good. Health providers safeguarding and looked after children annual reports are submitted and effectively scrutinised by both the LSCB and respective health trust boards.

4. The child death overview panel (CDOP) annual report is presented and scrutinised by the LSCB. The two designated doctors for child deaths are frequent attendees at CDOP, along with other health and partner agencies. The annual report contains good statistical analysis of the deaths and future work plans with recommendations, all of which are closely monitored. The CDOP is highly confident that all child deaths in Medway are reported to them. Action plans and recommendations from previous reports are well monitored, for example the ‘Safer Babies in Medway’ campaign and the availability of antenatal care records.
5. An initial report on children going missing will be presented to the Medway Safeguarding Children Board for the first time in the near future, and a new protocol is currently being consulted on, which includes improved arrangements for recording information. Good arrangements to identify children missing from education are in place, including liaison with health, and with independent schools.

6. Jointly commissioned services with Medway Council include speech and language therapy, young carers support, and the child and adolescent support team (CAST) who work with children and young people where early emotional wellbeing difficulties are becoming apparent.

Outcome 1 Involving Users

7. There is good service user involvement within all health services. Views from the ‘Parents of children with disabilities’ forums are used to inform the training provided to new parents as well as ensuring that targeting training is provided to meet the needs of foster carers/teachers and others who care for children with disabilities.

8. A new purpose designed ‘The Birthing Centre’ has very recently opened, providing a calm and safe midwifery led birthing experience. The centre was designed in consultation with previous parents and local National Childbirth Trust representatives. Early feedback from new parents is very positive.

9. There is an increasing implementation of the You’re Welcome’ quality criteria for young people friendly health service standards, within both the sexual health services and CAMHS; progress is slower in some services due to reconfiguration. Operationally the ‘voice of the child’ is starting to influence service delivery such as the tier 3 CAMHS retendering. Children, young people and their carers have been actively involved in the annual review by the Quality Network for Community CAMHS (CCQI), resulting in an annual report with recommendations being used to improve service development.

Outcome 2 Consent

10. Consent is obtained from the person with parental responsibility before the looked after child/young persons’ health assessment or review is undertaken. However, ascertaining who has parental responsibility for children and young people attending A&E at Medway Maritime Hospital is less well developed.

11. Consent is evident in the looked after children health assessment and review records. Further, consent is obtained when information sharing is required such as when investigating complaints.
Outcome 4 Care and welfare of people who use services

12. The looked after children and young people health services, - ‘Being Healthy’ is adequate. The looked after children health outcomes are showing declining rates in all national reported areas, although still generally remain in line with statistical neighbours. The recently introduced looked after children (LAC) database is showing early signs of improved monitoring and quality control of the health assessment process. The health outcome rates are: health assessments 80.4% (a fall of 8% from the previous year which is just below statistically neighbours and England averages,) immunisation rates are currently 84.8% a drop since February 2011 (national data return 2010, by the local authority reports a rate of 96%), however, still above statistical neighbours and England averages. Dental checks have fallen to 73.9%. The locally collated data for those looked after young people engaged with substance misuse services show that at least 25% of the total young people engaged with services are from the LAC population; however, the national reported return rates are variable for the past 5 years from 0% (current rate) to 5%

13. There remain too many ‘did not attend’ (DNA) appointments for LAC health assessments and reviews, which are contributing to the reduced capacity within the LAC team. There is limited evidence of effective use of the DNA process. Whilst this has been recognised, it is yet to be fully addressed. The remedial action which has been taken, including the on-line health assessment questionnaire for those older looked after young people and a wider choice of locations for health assessments, is just being implemented. The high DNA rate coupled with the increasing number of LAC (both Medway children and those from other authorities), has been highlighted at the Medway Foundation NHS Trust board, however, there is no evidence that this has been brought to the attention of the LSCB and Corporate Parenting Board or that any risk assessments completed. The LAC designated nurse occasionally provides a LAC health assessment service to both Medway LAC young people and other authority’s children and young people placed in the local youth offending institution.

14. The outcomes of the strength and difficulties questionnaires (SDQ) are infrequently used as part of the six monthly or annual LAC health assessments due to the lack of availability. Some SDQ scores are provided by children’s social care after the health assessment has been completed, resulting in an incomplete emotional health assessment. SDQ outcome scores from looked after children annual health assessment process are not included in the CAMHS referrals. There have been incidents when the Independent Reviewing Officers (IRO) has referred a young person to CAMHS, due to ongoing mental health and emotional wellbeing concerns, even though there has been no previous referral from children social care or health professionals despite concerns being recorded.

15. All new looked after children and young people health assessments are completed consultant paediatrician or on occasions the designated doctor; however, the occasionally late notification from social care is resulting in some assessments being completed just outside of the statutory period.
16. The designated nurse for looked after children does not report to, or is not held accountable by, the identified executive director for safeguarding and looked after children. The designated nurse looked after children is managed by the provider organisation and not by the commissioner, NHS Kent and Medway, and therefore do not fully fulfil their commissioning duties. The LAC annual report is presented to the Medway Foundation NHS trust board and is scrutinised along with the identified work plan for the coming year.

17. The LAC health team comprises of two named nurses with special interests; teenage conception/pregnancy and mental health (including substance misuse). This is allowing for improved targeted intervention with the most vulnerable young people. The work of the two specialist posts is closely monitored to ensure positive outcomes for the service users. Sample cases highlighted by the LAC team show that the roles are working effectively at promoting safeguarding for these vulnerable young people. There is good partnership working with other services such as; the sexual health outreach nurse, genito-urinary medicine, family nurse partnership, maternity and mental health services.

18. The LAC health team has limited involvement with the IROs in monitoring the health action plans. The LAC health team are not routinely attending the LAC panel liaison meetings to discuss cases of concern, which is a missed opportunity to improve information sharing. Front line practitioners report the need to attend an increasing number of LAC review meetings, partially attributed to the high number and increasing number of LAC, however, this is increase in numbers is making it difficult to attend all meetings. Information and notes from these meetings are not distributed in a timely way for follow action to be taken in an opportune way. GPs and community practitioners generally receive timely notification of new LAC and copies of health action plans.

19. The LAC health team receive notifications from Medway Foundation NHS Trust accident and emergency department, of a known LAC person’s attendance along with their attendance history, although currently there is no robust identification of LAC or ‘flagging’ system in place. The very recent access to the social care live database is starting to improve the safeguarding/child protection flagging, although it is too early review the robustness. The LAC team do not receive notifications from the other unscheduled care providers. All health visitors and school nurses report receiving A&E and unscheduled care notifications; however, those received by general practices do not contain information relating to the frequency of attendance. Appropriate action is taken to address any concerns identified in the notifications.

20. The LAC nursing team provides a highly valued and constantly evolving training programme for foster carers, (both new and established), residential care home staff and adoptive parents, all of which is contributing to healthy lifestyles and meeting the health needs of the child whilst promoting and supporting placement stability.
21. There is a ‘Personal Health Facts Handbook’ issued to all LAC at their request, which is adapted to meet the individual’s needs and may contain health history information. However, this is not always the case and it is not linked to the pathway plans. Care leavers may be supported until they are 19 years old, providing further opportunity for effective signposting to general health services, but they do not routinely receive copies of their health histories. The increasing number of LAC is stretching the capacity of the service, especially for those young people over 18 years old.

22. Child and adolescent mental health (CAMH) services has changed to a single point of access (SPA) for most referrals, except self harm, and those classified as a psychiatric emergency which are assessed and then sent directly to the appropriate specialist service. Most referred patients are offered a screening appointment, after the weekly triage meetings, and within the following 5 days for urgent cases or up to 4 weeks for non urgent cases. There is a further wait for treatment interventions to commence. Frontline and general practitioners all report that access to the service remains a challenge, with the telephone lines not being monitored over lunchtimes and at the end of afternoon surgeries or clinics, when practitioners are able to make the required referral telephone call, adding additional delays in the patient receiving treatment, advice or support. An on-line referral process to improve the timeliness of referrals is still to be implemented. There are a number of allocated daily emergency appointments but these are often allocated for self harm assessments, and not for other mental health needs assessments, which may result in children and young people staying in hospital for longer, or delays in urgent assessments which then become emergencies.

23. A&E staff report that out of hours access to CAMHS and mental health advice is variable and may take over three hours before the telephone request is responded to and then a further wait for a practitioner to attend the department. This is resulting in the young person being admitted to the children’s ward and an agency registered mental health nurse being employed, to ensure that the young person is cared for appropriately.

24. There are delays in accessing tier 4 CAMHS beds commissioned from South London and Maudsley NHS Foundation Trust outside normal working hours. The location of the service results in difficulties for some families to travel for appointments and visiting, potentially isolating the young person. At the time of the inspection a tender for a new tier 3 CAMH service has been published.

25. The designated Mental Health Act Section136 place of safety processes are not well known or understood by all partner agencies, which may result in the inappropriate use of A&E as a place of safety.
26. There is an effective 17-18 year old assessment and short term treatment service provided through Kent and Medway NHS and Social Care Partnership Trust, which is improving transitions. There is no waiting list for this service. However, there is no commissioned out of hours provision, this is dependent on support from the adult mental health services. The self harm team provide a Monday to Friday service, with practitioners visiting the acute children’s wards daily and undertaking assessments with family members present, which has improved discharge pathways and engagement with the follow-up services.

27. CAMHS ‘did not attend (DNA) and ‘fail to engage’ informal procedures are adhered to. A revised policy is awaiting ratification and service developments to improve engagement of young adults are yet to be implemented. Children social care workers are informed if a looked after child/young person does not attend appointments, in order to follow up the young person, however, feedback on actions taken is not robust. There is no dedicated CAMHS fast track access for LAC, although the local authority has seconded a member of staff for these purposes and the provider does include LAC status as one of the criteria for prioritisation. However, there is good communication with the dedicated LAC nurse with a mental health remit, to identify those LAC who need a service form this post holder, although the post has very limited capacity.

28. Thresholds for safeguarding referrals to children social care are generally well understood. Some staff report that there remains a challenge in the acceptance of referrals for emotional neglect/abuse and hidden harm, requiring successful use of the escalation policy. Frontline practitioners interviewed reported that contact with and getting referrals accepted out of hours is variable. Thresholds for referral to social care are laminated and clearly displayed in the A&E. Pathways are well understood, with increasing clarity related to referrals for domestic violence.

29. There is good acceptance of safeguarding referrals for identified vulnerable unborn babies with effective strategy and pre-birth planning meetings. There has been an improved recording template which has enabled better record keeping and monitoring of risk factors as a result of a serious case review. The collection and discharge of babies to foster carers is delayed in approximately 30% of cases partially due to late obtaining of court orders, resulting in longer stays in the maternity unit, and is contrary to the agreed length of stay policy. Maternity staff highly value the role of the named midwife in championing safeguarding issues and concerns. Staff report that the post holders passion and drive has had a positive impact on services and outcomes for babies and their families. There are robust systems for notification of out of area pregnant women who are identified as high risk cases or who go missing.
30. The use of the common assessment framework (CAF) is not robust. Frontline practitioners report that as family agreement is required this is not always forthcoming, particularly for chaotic families and those using mental health services, resulting in the non-progress of CAF. Community practitioners, GPs and maternity staff are aware of the need to initiate more CAFs but, limited capacity, lack of administration support and the limited capacity of preventative services is impeding progress, and instead staff may make an inappropriate safeguarding referral to children’s social care to ensure the child is safeguarded. Midwives report that the criteria for a CAF would result in all teenage parents requiring a CAF and there is no capacity to achieve this. The Family Nurse Partnership (FNP), although involved in CAFs, find that this is a duplication of their work and therefore may not initiate a CAF.

31. A new CAF pilot, within maternity services which commenced in September 2011. It is aiming to improve the engagement of maternity services and provide better support for families where for example there are concerns for maternal mental health and for pregnant women who are also substance misusers. It is too early to measure the impact of this.

32. Young people’s transition pathways from mental health and learning disability services to the respective adult service, remains underdeveloped. The transitional operational group reviews cases that do not meet the thresholds for adult services; however, there remains a lack of commissioned provision for young adults this result in some paediatric services, for example, CAMHS, continuing to support the most vulnerable cases.

33. Universal health screening and health prevention remains a challenge due to the lack of capacity within health visiting and school nursing services. Obesity rates in year 6 children remains higher than England averages. The indicator for physical education for three hours per week is nearly half that of the England average indicating a poor rate of compliance. Chlamydia screening rates (outside of GUM) are significantly better than England averages. Human papillomavirus vaccine (HPV) take up is in line with other providers in the region. Immunisation rates for all children remain above England averages (February 2011). Breastfeeding initiation rates remain low.
Outcome 6 Co-operating with others

34. There are good partnerships with the safer school (which includes school nursing services) and police services, as well as work with the local Police Community Support Officers (PCSOs), who providing a targeted response, for example, to the local black and ethnic communities. Joint partnership working between youth services, school staff and PCSOs is providing a visible and accessible presence that is helping to reduce individual risk taking behaviours and vulnerabilities, especially amongst teenagers who are at risk of offending, taking substances or becoming pregnant. Funding has recently been awarded for a dedicated psychology service however; the posts are proving hard to recruit. Substance misuse is assessed on LAC health assessments and reviews, in an age appropriate manner if consent is given. The application of the drug use screening tool (DUST) is used and positive results trigger a referral to the specialist services. A recently introduced health database is starting to collate data on the outcomes of the health assessments and onward referral; however, it is too early for impact measurements.

35. The Goldilocks groups, which involve both parents and foster carers, provide a good range of therapeutic teaching and role model behaviours within the pre-school age children with disabilities. These groups are also providing at least four therapeutic interventions within one appointment, therefore reducing the number of appointments that the family are required to attend. Similar good provision is provided through the special schools, such as addressing the needs of fussy eaters.

36. Transition for children with disabilities in special schools starts in year 9, although some of these young people remain in school until 19 years of age. However, this is not the same for those in mainstream schools resulting in an inconsistent approach, confusing parents and resulting in inconsistent access to services. Whilst there has been some improvement in the range of services provided by adult health, there still remain a number of gaps, especially for those children with complex needs, as their prime health care contact is their GP. There was a disabilities liaison nurse, who had helped to provide smoother transitions for some young people, however, the post holder left recently and has not been replaced. There is limited access to clinical psychology services. There is poor access to alternative communication devices, with, on average, a two year waiting list.

37. School nurses, within the limited capacity available, give good support to educational staff to provide a range of personal and sexual health and relationship education. The Sexual Health Improvement and Student Health Service provide a range of sexual health education programmes to meet the individual needs. There has been a recent staffing reduction (4 posts) within the teenage pregnancy teams, and the specialist midwifery role has been replaced with a generic midwife in each of the four geographical teams who have pregnant teenagers on their case load. The impact of this is yet to be assessed. The sexual health outreach services are highly valued by the midwives for the support that they provide both to the midwife and the teenage parent.
38. The genito-urinary medicine service provides an adequate range of drop-in clinics, which include sexual transmitted disease testing and the condom card (C-card) scheme; however, there is no evening clinic or weekend clinic. Consultation with young people has identified the need for some service reprovision but at the time of the inspection this had not been introduced.

39. Staff working in sexual health services, community and primary care services are concerned at the closure of the Chatham based sexual health clinic, Elm House, which has been well used by young people across Medway, due to the fact that it can be accessed anonymously. The building is closing as it is not fit for purpose. The reprovision, in the four Healthy Living Centres, will result in no provision in Chatham, which is one of the hotspot areas for teenage conceptions. Staff are unclear as to the information provided to young people regarding the service changes and the future impact on the already high teenage conception rate in the area.

40. Whilst there is recognition that long acting reversible contraception (LARC) is not regularly promoted or used due to a lack of confidence and competence with some health practitioners, there are no plans known by sexual health practitioners to address this. However, commissioners are contracting with general practitioners to commence LARC services from general practice locations.

41. Teenage conception rates across Medway are 46/1000 (2010) and are the highest in the South East area. This is being addressed through the Teenage Pregnancy Strategy and the Family Nurse Partnership who are working to improve contraception and sexual health services. The youth offending team (YOT) including the YOT educational worker and the KCA workers, (substance misuse service) have good links with the health preventative services and those services aimed at reducing vulnerabilities and risk taking behaviours, which are providing a good ‘wrap around’ service for the young person.

42. Young carers value the support that they receive and are positive about the opportunities that they have had to present to the Carers Partnership Board. However, young carers report that some schools do not recognise the responsibilities that they carry and some health agencies are unwilling to share important health information with young carers, even if they are the main carer for that person.
Outcome 7 Safeguarding

43. The contribution of health agencies to keeping children and young people safe is adequate. There is a good level of commitment to safeguarding from all health providers and commissioners, demonstrated by the very recent increase to funding, to improve safeguarding health team’s capacity. There has also been an investment in some specialist nurse posts such as domestic violence, which has improved the joint working with other agencies and engagement with the multi agency referral and assessment conference (MARAC). Infrastructures for individual trust safeguarding governance structures has improved, with better monitoring of action plans for serious case reviews and section 11 safeguarding audits. KMPT have introduced safeguarding champions, to support frontline staff, however, progress has been slow due to the number of interim senior managers, causing a feeling of instability in frontline staff.

44. There remains a variable, but improving GP training compliance, with increased use of the Royal College of General Practitioners safeguarding toolkit. Forty-one of the sixty-two GP practices have an identified safeguarding lead and further training for the leads is planned in the near future. Increasing engagement of GPs within the local partnership arrangements and through the emerging clinical commissioning groups is ensuring that safeguarding remains central to decision making.

45. The higher number of safeguarding referrals has increased the workload of health visitors and school nurses, which is distracting them from universal and core provision. Community practitioners have very good rates of attendance at conferences, 100% of initial assessment and 90% at reviews meetings. There still remains a challenge for primary care staff to attend conferences. Frequently GPs receive short notice (2-3 days) to attend initial case conferences; requests are not sent electronically which increases delays. This is resulting in a lack of attendance, as surgeries are unable to be cancelled especially with the single handed practices. Case conference reports are submitted. GPs interviewed stated that they had not receive a response from social care to their request for case conferences to be held in the practice and/or over lunchtimes, to increase GPs attendance.

46. Substance misuse services have a good focus on early intervention with a wide range of health prevention and promotion activities supported by all partners. However, evaluation of the effectiveness of these interventions is under developed. The use of the ‘clever thinking’ and the ‘aspirations’ health prevention programmes have been positively evaluated by the young people. Further, there is good use of the ‘SOS Bus’ delivering outreach work and targeted activities at night clubs and other areas where young people gather, providing a safe haven for those young people who may be under the influence of alcohol or substances. There is effective joint working with the sexual health services, resulting in substance misuse services offering the c- card (condom service) and Chlamydia screening.
47. The diversion scheme funded by the Department of Health and Department of Justice, working through partnerships with the police, KCA (local commissioned Kent and Medway substance and alcohol service) along with the established drug intervention support programme, provides effective triage services, identifying those at high risk of offending, or first offenders, and diverting them from the court system.

48. Hidden harm and links to the MARAC are developing further following the funding for a dedicated hidden harm practitioner post. There is an improving dedicated service provided in the antenatal clinics to identify domestic violence and mental health concerns. Anecdotal evidence shows that this provision is providing early intervention and support to new mothers if their baby is taken into care. There are good systems in place to support vulnerable substance misusing pregnant women, with effective joint working and clinic appointments, which is improving treatment compliance.

49. There is an improved awareness of domestic violence across health providers, with better identification and notification of domestic violence concerns within pregnant women, services adhere to NICE guidance. There is good engagement with MARAC, with improving communication with the police. However, the sharing of police attendance reports relating to pregnant women who have been subject to an incident of domestic violence, or those not meeting the thresholds for MARAC, is not robust and has further reduced since the loss of the paediatric liaison post. New systems are yet to be embedded. The lack of a paediatric liaison post in A&E has been identified as a gap in service within both A&E and community services, and identified as a risk on the A&E risk register. This is because communication and quality assurance monitoring that all children who have visited the A&E department have been notified to community staff and general practice, is now less robust. Remedial action is being undertaken by MFT at the time of the inspection to address this and reinstate the liaison role.

50. The sexual assault referral centre (SARC) service for those young people over the age of thirteen years is provided from Darent Valley Hospital, located outside of the Medway local authority area. Those under thirteen years are seen at Medway Foundation NHS Trust by community paediatricians and a Forensic Medical Examiner (FME). However, there is no forensic facility at Medway Maritime Hospital site. The SARC policy permits self referrals however, the operational procedure state referrals will only be accepted from social services and police. The service for young people under 13 years of age is not a forensic service and is only available Monday to Friday 9am to 5pm. There are no services, outlined in operational procedure, for outside of these times. Staff interviewed confirmed, if required, they would inform the police who would provide a service.
Outcome 11 Safety, availability and suitability of equipment

51. Accident and emergency services (A&E) are based at Medway Maritime Hospital, part of the Medway Foundation NHS Trust. There is a dedicated children and young person minor area and two allocated resuscitation bays but these are located in the adult trolley and resuscitation area, and it has been recognised that these are not fit for purpose. Building work on a new extension is due to commence October 2011. There is no fully segregated, (i.e. away from the adult areas) child waiting area. Security in the current A&E department is inadequate. During the inspection, members of the general public were seen accessing the department through an unauthorised egress in the ‘majors area’, where patients (both children and adults) were on trolleys, compromising their privacy and dignity. This open access may result in children leaving the department unobserved especially as this is a busy area of the department. Staff report that this is a frequent problem, not just with members of the public, but other staff using this as a shortcut to exit the hospital. There were no security staff seen in the department during the inspection visit. The plans for the new children A&E area do include security coded access.

52. Funding for those Medway LAC who are placed out of area who require medical equipment e.g. ventilators is limited, resulting in a delayed discharge from hospital.

Outcome 12 Staffing recruitment

53. There is a named GP in post, which had been vacant for a number of years. There is a stable designated nurse and doctor workforce, with formalised reporting structures, although not all the designated posts have access to, or are accountable to, their organisations’ executive director for safeguarding. Executive directors receive regular assurance regarding the criminal record bureau check (CRB) status of their own employees, although assurance regarding the CRB clearance for contracted staff is less robust, and there has been only limited contract monitoring.

Outcome 13 Staffing numbers

54. There are dual trained and dedicated children qualified health staff within the dedicated children A&E, however, the service is only open daily until 12 midnight, and registered children staff may not be on duty overnight resulting in children being admitted not having access to specialist children nurses. Staffing establishments within health visiting and school nursing services are still to be reached. Skill mix reviews are currently in progress. The health visiting service is recognised national as an early implementer site for ‘Action on Health Visiting’.
Outcome 14 Staffing support

55. There is good access to the highly valued LSCB multi agency level 3 safeguarding training. Staff interviewed confirmed that level 1 safeguarding training is mandatory for all staff and they were up to date with their training, as defined for their role. There are a wide and good range of thematic training sessions based on the needs of staff. The impact of training on practice is underdeveloped, however, the limited evaluation within maternity services shows that there has been an improvement in both the quality and number of safeguarding referrals. As a result of a cultural shift in referral patterns following training, the recent referral data shows that within the Cheatham area, (a teenage pregnancy hotspot area), there has been an increase in referrals with the highest recorded (19) unborn baby child protection cases, in the Medway area.

56. Whilst training strategies are in place, (MFT strategy is awaiting ratification) recording does not show that these are fully implemented. Training databases, at the time of the inspection, were recognised as not being robust. Training data shows that at the MCH compliance at level 2 is only 87%, and at level 3 is at 94% in August 2011. At MFT 92% of staff have completed level 1 and 2 training, however, only in October 2011 did level 1 training become part of the induction programme for all new staff. MFT do not monitor level 3 safeguarding training compliance, a plan to monitor this in the future has been included in the revised draft training strategy.

57. At KMPT level 1 training compliance rate is 94%, however, level 2 and 3 (including CAMHS) is only between 72-79%. (August 2011). Within general practice of the 180 GPs in post, over the past two years only 72% of GPs have completed level 1 or level 2 training. There have been dedicated sessions for practice nurses, and other practice staff, with 124 practice staff trained in addressing domestic violence recently; there is no evaluation of the impact of this training on practice.

58. There is good access and monitoring of safeguarding supervision within maternity services. As well as formal supervision there is access for all staff, excluding obstetrics staff that do not access safeguarding supervision, to telephone support and advice and group supervision. Supervision in the A&E department is not systematic and does not include all clinical staff on a regular basis. There is however, good use of debriefing sessions following a child death. The MFT supervision policy is currently under review, aiming to improve access and take up of supervision.

59. Professionals working with children who have a disability have good access to a range of safeguarding supervision, improving their response to safeguarding concerns and providing ongoing support when managing a case of concern.

60. There is highly visible support and supervision and reflective practice meetings from the named nurse and named GP within Medway Community Healthcare and NHS Kent and Medway. Youth offending team workers have good access to and regular safeguarding supervision with both the named nurses for safeguarding and LAC.
61. General practitioners interviewed highly valued the regular support and supervision from the named GP or the designated nurse for safeguarding.

Outcome 16 Audit and monitoring

62. Health trust boards receive assurance of the implementation of safeguarding policies through a range of performance monitoring and audit tools; however, there is recognition that these still require further work to enhance the quality and benchmarking data in the reports.

Outcome 20 Notification of other incidents

63. No staff interviewed have used the whistle blowing procedures. Staff had reported significant incidents and these are risk rated and reported to the health organisations trust board.

Outcome 21 Records

64. All looked after children (LAC) health records, seen during the inspection complied with both statutory and professional record keeping guidance. There is however, a variable quality in the recording of the timescales within the health action plans which are not always smart and do not allow for effective monitoring. There is some evidence in the records of follow-up of the action plans.

Recommendations

(Those in italics are in full or part in the joint published report with OFSTED)

Looked after children

3 months

Medway Council and NHS Kent and Medway to ensure that all care leavers receive a copy of their health histories to equip them to make effective future health choices

Medway Council and NHS Kent and Medway to ensure that the outcomes from the strengths and difficulties questionnaires are used within the looked after children health assessments.

NHS Kent and Medway to ensure that the ‘did not attend’ rates for looked after children health assessments are significantly reduced.
Safeguarding

Immediately

*NHS Kent and Medway and Medway Foundation NHS Trust* to ensure adequate security arrangements at Medway Maritime Hospital accident and emergency department to ensure that only legitimate individuals have access to patients areas, especially those where children and young people are located, to maintain their safety, privacy and dignity.

3 months

*NHS Kent and Medway* must ensure an appropriate designated Mental Health Act Section 136 place of safety that all partner agencies are aware of and there is timely access 24 hours a day for mental health advice and assessments to provide appropriate treatment interventions.

*NHS Kent and Medway and Medway Foundation Trust* to ensure that plan for a dedicated and upgraded children and young people A&E department is not impeded and in the meantime children and young people are seen in separate areas from adults at all times of day and night, to maintain their safely, dignity and privacy.

*NHS Kent and Medway and Kent and Medway Council* to ensure timely access to the CAMHS single point of access referral system throughout the working day, to enable timely referrals to be made by all health practitioners.

*NHS Kent and Medway* must ensure that there is equality of access to forensic sexual assault referral services for all young people, at all times.

Medway Foundation NHS Trust must ensure that there is sufficient staffing capacity to deliver the strategic priorities relating to common assessment frameworks.

Medway Foundation NHS Trust must ensure that all staff as defined by the ‘Working Together to Safeguard Children’ who require safeguarding training receive this at the appropriate level for their role in line with this statutory guidance.

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.